# MEDICAID FUNDING CRISIS

# HEARING

BEFORE THE

## HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE

OF THE

## COMMITTEE ON GOVERNMENT OPERATIONS HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

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DECEMBER 7, 1990

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# MEDICAID FUNDING CRISIS

FRIDAY, DECEMBER 7, 1990

HOUSE OF REPRESENTATIVES,
HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE
OF THE COMMITTEE ON GOVERNMENT OPERATIONS,
*Washington, DC.*

The subcommittee met, pursuant to notice, at 9:30 a.m., in room 2154, Rayburn House Office Building, Hon. Ted Weiss (chairman of the subcommittee) presiding.

Present: Representative Ted Weiss.

Also present: Representative Mike Synar.

Staff present: Marc Smolonsky, professional staff member; Ann Marie Atkins, staff assistant; and Jim Cantwell, GAO detailee.

## OPENING STATEMENT OF CHAIRMAN WEISS

Mr. WEISS. Good morning.

The Human Resources and Intergovernmental Relations Subcommittee is now in session.

Let me indicate my very sincere appreciation to our distinguished colleague, Mr. Synar, for coming in. He is a member of the full committee, not a member of the subcommittee, but his presence makes it absolutely, without a doubt, that we have authority to hold the hearing at this point, so we are grateful to you, Mike. We are pleased for whatever length of time you can stay with us.

Today we will hear charges by the General Accounting Office that unfairness in the Medicaid funding formula is costing the poorest States $3.2 billion. This unfairness may be fueling budget crises in many States while limiting access to health care for Americans living in poverty.

Revenue losses are forcing State programs across the country to slash budgets. Contributing to the problem of State revenue losses are the inflationary health care costs and congressionally-mandated expansions that have made Medicaid a major strain on State budgets. This year, Medicaid is expected to cost nearly $80 billion, an increase of $19 billion in just 2 years.

As a result of the fiscal crisis, State Medicaid payment rates are not keeping pace with costs. Hospitals and nursing homes in 13 States have filed lawsuits, charging that Medicaid payment rates are not adequate to cover the costs of health care to the poor. In my own State of New York, 85 percent of physicians do not participate in Medicaid because of low fee charges.

Despite these astronomical amounts of money spent on Medicaid, a shocking number of Americans lack health care coverage. As

many as 37 million Americans have no health care insurance at all, and this number is increasing. Nearly 11 million of the uninsured live below the poverty line. There has been a steady decline in the proportion of America's poor who are covered by Medicaid. Because of the high costs of the program, most States limit access to Medicaid.

Exacerbating the budget crisis is the AIDS epidemic. Medicaid currently funds 25 percent of health care costs for AIDS, and that percentage will increase as the disease settles into the groups at the bottom of the economic scale. Every year, the number of AIDS patients covered by Medicaid increases while the number covered by private insurers declines.

We will hear testimony today from the General Accounting Office that one of the causes of the Medicaid budget crunch may be the formula used by the Federal Government to reimburse the costs of Medicaid. The formula uses an inaccurate method to count the poor and measure each State's ability to fund Medicaid. As a result, GAO has found that the States with the most poor people are not receiving their fair share of Federal reimbursements.

GAO believes the unfairness in the funding formula allows States with the fewest Medicaid patients to provide a wider range of services to their poor, while States with the largest poverty populations are forced to limit access to health care.

Also testifying today will be the Governor of Arkansas, the Honorable Bill Clinton; the Administrator of the Health Care Financing Administration, Gail Wilensky; and representatives from the American Association of Retired Persons and the Children's Defense Fund.

Mr. Synar, if you have opening comments, we will be pleased to recognize you at this point for that purpose.

Mr. SYNAR. This is an important issue, and I commend you.

In the 102d Congress, one of the major issues will be health care and these hearings today, I think, will be the beginning of what will probably be the most extensive review of our health care policy in this country, and ignoring Medicare and Medicaid problems would be ignoring a large portion of the problems, so I commend you on this hearing.

Mr. WEISS. Because this is an informational hearing and not an investigative one, we will not be swearing in witnesses this morning.

Our first witness is Janet Shikles, Director, Health Financing and Policy Issues, Human Resources Division, General Accounting Office.

Ms. Shikles, do you have any associates accompanying you?

**STATEMENT OF JANET L. SHIKLES, DIRECTOR, HEALTH FINANCING AND POLICY ISSUES, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY JERRY FASTRUP, SENIOR ECONOMIST, AND JAMES LINZ, ASSISTANT DIRECTOR**

Ms. SHIKLES. Yes.

Mr. Chairman, I would like to introduce my colleagues with me today.

On my right is Jerry Fastrup from GAO; and on my left is James Linz.

Mr. Chairman and members of the subcommittee, I am pleased to be here today to discuss the formula used to share the cost of Medicaid between the Federal Government and the State governments.

Medicaid is a jointly funded Federal-State program providing health care to qualified low-income people. Under this program, the Federal Government pays about 55 percent of eligible medical expenses and States finance the remaining 45 percent. The Federal share varies from 50 to 80 percent for individual States. In fiscal year 1990, a total of $71 billion was projected to be spent on health care services for the poor.

The current Medicaid formula, which was adopted in 1965, had two major objectives: One, reducing differences among States in medical care coverage of the poor; and two, distributing fairly the burden of financing program benefits among the States.

These objectives, however, have not been met. Nationwide, the program covers 75 percent of those below the poverty line, but coverage varies from 37 percent in Idaho to 111 percent in Michigan. Also, States face varying fiscal burdens in providing for those in need. This happens, in part, because the formula does not target most Federal funds to States with the greatest needs; that is, those with weak tax bases and high concentrations of poor people.

In response to your request, we have analyzed some of the problems with the Medicaid formula. Today I would like to discuss some of these problems and some proposals.

The legislative history of the Medicaid formula shows that Federal policymakers believed that by financing a larger share of total program costs in States with high poverty rates and weak tax bases States would provide comparable benefits. They also thought that per capita income could be used to reflect the greater burden of high poverty rates under the assumption that low-income States experienced a greater incidence of poverty.

The use of per capita income causes the Federal share for each State to vary. Mississippi, with the lowest per capita income, receives 80 cents from the Federal Government for each dollar it spends. Higher-income States receive a lower Federal share. However, current law guarantees that no State will have to pay more than half of the total cost of its Medicaid program.

When income-based formulas were first adopted in the 1950's, per capita income was probably the best available indicator of both States' ability to finance program benefits and the incidence of poverty. Today, however, we believe there are better measures.

One of the most significant weaknesses of per capita income as an indicator of a State's ability to finance program benefits is that it does not reflect all the income States are potentially able to tax. For example, corporations retain some of their profits for investment purposes. This business income is not reflected in State per capita income even though States are able to tax it through corporate income taxes. This means that using per capita income understates the revenue-raising capacity of States with comparatively high percentages of business income.

The Department of Commerce now provides estimates of total income produced within each State, in addition to the income received only by State residents. With this data, the Department of the Treasury estimates States' total taxable resources, called TTR. Because TTR is a better measure of States' financing capacity than per capita income, the Congress approved its use as a substitute for per capita income for distributing Federal funds under the Alcohol, Drug Abuse and Mental Health Services block grant program.

Differences in TTR and per capita income are substantial in some instances. As you can see in the first graph, we have illustrated some of the more extreme cases. The five States where per capita income understates total taxable resources the most are Alaska, Wyoming, Louisiana, New Mexico, and Texas. At the other extreme, per capita income overstates taxable resources the most in Maryland, Florida, Rhode Island, Pennsylvania, and New Hampshire.

As a consequence, the Federal share of Medicaid is too low in States where financing capacity is overstated by using per capita income. Data comparing per capita income and TTR for all 50 States are shown in attachment I.

Turning to another problem, per capita income is also a poor proxy for the incidence of poverty because two States with the same per capita income can have very different poverty rates. Because Arkansas and Utah both have almost the same average per capita income, the formula treats them as if they had the same poverty rate. Actually, Arkansas has a poverty rate of 32 percent, Utah's is 20 percent.

Turning to another pair of States, Texas and Iowa also have similar per capita incomes, but the Texas poverty rate is 25 percent and in Iowa it is 17 percent. Likewise, New York's is 22 percent and Maryland's 17 percent, even though they have the same average per capita income.

To determine the effect of changing the Medicaid formula, we have conducted an analysis that replaces per capita income with TTR and State poverty rates. We also reduced the 50 percent guaranteed Federal share to 40 percent.

We did our analysis using fiscal year 1989 data and kept Federal spending the same as under the current formula. This means that for this analysis, funding increases for gaining States are financed by reducing Federal aid for losing States. We made this assumption so that we could provide a quantitative measure of how much fiscal year 1989 funding would be reallocated using this different formula.

Our illustration shows that from the standpoint of equalizing the tax burden on State taxpayers, the revised formula would have reallocated $3.2 billion, or 17 percent of all Federal Medicaid assistance in fiscal year 1989. About nine States would have received an additional $100 million or more if that formula had been used that year. These States are Arkansas, California, Florida, Georgia, Kentucky, Mississippi, New York, Tennessee, and Texas. The figures also show that the current formula benefits States concentrated in the Great Lakes and Midwest regions of the country.

In conclusion, Mr. Chairman, we believe a formula that uses better indicators of States' financing capacities and poverty rates

and reduces the minimum Federal share would more equally distribute the burden State taxpayers face in financing Medicaid benefits for their low-income residents. If the use of such a formula continues to be the intent of Congress, we believe the Congress should consider revising it along the lines I have suggested. Doing so would enhance one of the major objectives of the formula, distributing fairly the burden of financing program benefits among States.

However, these changes would substantially reallocate funding among the States, as I have described. A less disruptive approach would be to apply a revised formula only to new Medicaid spending that exceeds the funding level existing before implementation of a new formula.

Mr. Chairman, this concludes my statement and I would be very happy to answer any questions.

Mr. WEISS. Thank you very much, Ms. Shikles.

[The prepared statement of Ms. Shikles follows:]

United States General Accounting Office

GAO Testimony

For Release
on Delivery
Expected at
9:30 a.m. EST
Friday
December 7, 1990

# MEDICAID FORMULA: Fairness Could Be Improved

Statement of
Janet L. Shikles, Director, Health
Financing and Policy Issues
Human Resources Division

Before the
Subcommittee on Human Resources
and Intergovernmental Relations
Committee on Government Operations
House of Representatives

GAO/T-HRD-91-5

GAO Form 160 (12/87)

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the formula used to share the cost of Medicaid between the federal and state governments.

Medicaid is a jointly funded federal-state program providing health care to qualified low-income people. Under this program, the federal government pays about 55 percent of eligible medical expenses and states finance the remaining 45 percent. The federal share varies from 50 to 80 percent for individual states. In fiscal year 1990 a total of $71 billion was projected to be spent on health care services for the poor.

The current Medicaid formula, which was adopted in 1965, had two major objectives:

-- reducing differences among states in medical care coverage of the poor and

-- distributing fairly the burden of financing program benefits among the states.

However, these objectives have not been met. Nationwide, the program covers 75 percent of those below the poverty line. But coverage varies from 37 percent in Idaho to 111 percent in Michigan. Also, states face varying burdens in financing the cost of providing for those in need. This happens, in part, because the formula does not target most federal funds to states with the greatest needs; that is, those with weak tax bases and high concentrations of poor people.

In response to your request, we have analyzed problems with the Medicaid formula.[1] Today, I would like to discuss:

-- How the current formula calculates the federal share of benefit costs in each state.

-- How the formula could be modified to reflect more directly the relative taxing capacity of each state and the fraction of each state's population that is in poverty.

-- The effect of substituting a formula that measures fiscal capacity and the poor more directly.

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[1] The work summarized here is an update of our earlier report Changing Medicaid Formula Can Improve Distribution of Funds to States, (GAO/GGD-83-27, Mar. 9, 1983).

## CURRENT FORMULA USES PER CAPITA INCOME TO DETERMINE FEDERAL SHARE OF MEDICAID

The legislative history of the Medicaid formula shows that federal policymakers believed that by financing a larger share of total program costs in states with high poverty rates and weak tax bases states would provide comparable benefits. The policymakers thought that per capita income could be used in the formula as a good measure of differences in the abilities of states to finance program benefits. They also thought that per capita income could be used to reflect the greater burden of high poverty rates under the assumption that low-income states experienced a greater incidence of poverty. Since per capita income is serving two functions, it enters the formula with its value squared.

The use of per capita income causes the federal share for each state to vary. Mississippi, with the lowest per capita income, receives 80 cents from the federal government for each dollar it spends.[2] Higher-income states receive a lower federal share. However, current law guarantees that no state will have to pay more than half of the total cost of its Medicaid program. Under this approach, 12 higher-income states receive a higher federal share than they otherwise would.[3]

## BETTER INDICATORS OF STATE NEED ARE NOW AVAILABLE

When income-based formulas were first adopted in the 1950s, per capita income was probably the best available indicator of both states' ability to finance program benefits and the incidence of poverty. However, in the intervening years, better and more direct measures of states' financing capacities and poverty rates have become available.

### Per Capita Income Is Not a Comprehensive Measure of All Income

Perhaps the most significant weakness of per capita income as an indicator of a state's ability to finance program benefits is that it does not reflect all the income states are potentially able to tax. For example, corporations retain some of their profits for investment purposes. This business income is not

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[2]Without squaring, the federal share for Mississippi would be 69 percent instead of 80 percent.

[3]Alaska, California, Colorado, Connecticut, District of Columbia, Illinois, Maryland, Massachusetts, Nevada, New Hampshire, New Jersey, and New York.

reflected in state per capita income even though states are able to tax it through corporate income taxes. Similarly, significant portions of business income are received by out-of-state residents, such as when dividends are paid to stockholders who live elsewhere. This, too, is not reflected in state per capita income. Yet, states can tax this income through various state business taxes. This means that using per capita income understates the revenue-raising capacity of states with comparatively high percentages of business income.

The Department of Commerce now provides estimates of total income produced within each state, in addition to the income received only by state residents. With this data, the Department of the Treasury estimates states' total taxable resources, called simply TTR. TTR is a more comprehensive measure of states' ability to finance program benefits because it reflects both income produced within the state and income received by state residents, even if received from out-of-state sources. Because TTR is a better measure of states' financing capacity than per capita income, the Congress approved its use as a substitute for per capita income for distributing federal funds under the Alcohol, Drug Abuse and Mental Health Services block grant program. In fiscal year 1990 about $1.2 billion was distributed under this formula.

Differences in TTR and per capita income are substantial in some instances. Figure 1 illustrates the most extreme cases. The five states where per capita income understates taxable resources the most are Alaska, Wyoming, Louisiana, New Mexico, and Texas. At the other extreme, per capita income overstates taxable resources the most in Maryland, Florida, Rhode Island, Pennsylvania, and New Hampshire. As a consequence, the federal share of Medicaid is too low in states where financing capacity is overstated by using per capita income. Data comparing per capita income and TTR for all 50 states are shown in attachment I.

Per Capita Income Is a
Poor Measure of Poverty

Per capita income is also a poor proxy for the incidence of poverty because two states with the same per capita income can have very different poverty rates. Because Arkansas and Utah both have almost the same average per capita income, the formula treats them as if they had the same poverty rate. However, Census data show that Arkansas's poverty rate is 32 percent, and Utah's is 20 percent, as shown in figure 2. Similarly, Texas and Iowa have per capita incomes near the national average, but Texas's poverty rate is 25 percent, and Iowa's is 17 percent. Likewise, New York's is 22 percent, and Maryland's is 17 percent. Data for all 50 states are included in attachment II.

Because per capita income does not accurately reflect differences for financing capacities and poverty rates, the burden of financing the needs of the poor is greater in some states than in others. In addition, the guaranteed 50-percent minimum federal share of Medicaid costs also enables states with high taxable resources and low poverty rates to finance the needs of their poor with comparatively low tax burdens.

USING BETTER NEED INDICATORS WOULD REDISTRIBUTE FUNDING AMONG STATES

Replacing per capita income with more accurate measures of states' financing capacities and poverty rates would offset the fiscal disadvantage that low-tax-base, high-poverty-rate states face under the existing formula. Coupled with these changes, lowering the guaranteed 50-percent federal share would also help equalize the Medicaid burden facing state taxpayers.

To determine the effect of changing the formula, we conducted an analysis that replaces per capita income with TTR and state poverty rates. We also reduced the 50-percent guaranteed federal share to 40 percent.

We did our analysis using fiscal year 1989 data and kept federal spending the same as under the current formula. This means that, for this analysis, funding increases for gaining states are financed by reducing federal aid for losing states. We made this assumption so that we could provide a quantitative measure of how much fiscal year 1989 funding would be reallocated.

Our illustration shows that, from the standpoint of equalizing the tax burden on state taxpayers, the revised formula would have reallocated $3.2 billion, or 17 percent, of all federal Medicaid assistance in fiscal year 1989. Figure 3 identifies nine states that would have received an additional $100 million or more under the revised formula: Arkansas, California, Florida, Georgia, Kentucky, Mississippi, New York, Tennessee, and Texas. The figure also shows the current formula benefits states concentrated in the Great Lakes and Midwest regions of the country. Attachments III and IV provide details for all 50 states.

CONCLUSION

Mr. Chairman, we believe a formula that uses better indicators of states' financing capacities and poverty rates and reduces the minimum federal share would more equally distribute the burden state taxpayers face in financing Medicaid benefits for their low-income residents. If the use of such a formula continues to be the intent of the Congress, we believe the Congress should consider revising the formula along the lines I have suggested. Doing so would enhance one of the major objectives of the

formula: distributing fairly the burden of financing program benefits among states.

However, these changes would substantially reallocate funding among the states, as I have described. A less disruptive approach would be to apply a revised formula only to new Medicaid spending that exceeds the funding level existing before implementation of a new formula.

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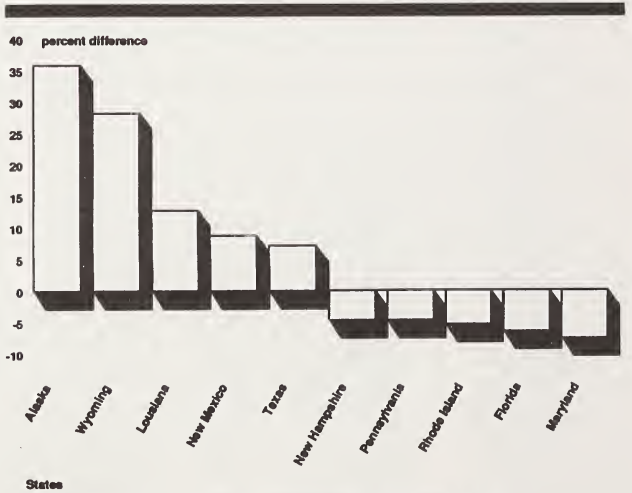
Mr. Chairman this concludes my statement. I would be happy to answer any questions you may have. Thank you.

**FIGURE 1: DIFFERENCES IN STATE PER CAPITA INCOME AND TOTAL TAXABLE RESOURCES**

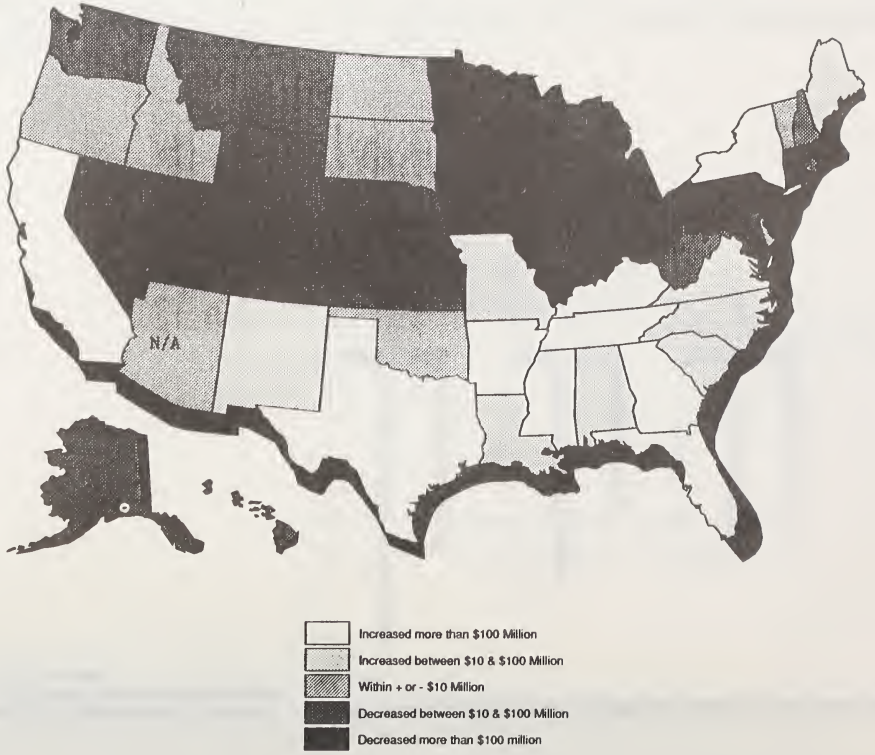



positive differences denote per capita income understates total taxable resources

negative differences denote per capita income overstates total taxable resources

FIGURE 2: COMPARISON OF POVERTY RATES FOR STATES WITH EQUAL PER CAPITA INCOME

FIGURE 3: MEDICAID FUNDING REDISTRIBUTED


N/A
Increased more than $100 Million
Increased between $10 & $100 Million
Within + or - $10 Million
Decreased between $10 & $100 Million
Decreased more than $100 million

ATTACHMENT I

ATTACHMENT I

COMPARISON OF PER CAPITA INCOME WITH TOTAL TAXABLE RESOURCES PER CAPITA

| State | Index No., U.S. = 100 Per Capita Income | Per Capita Taxable Resources | Percent Difference |
|---|---|---|---|
| Alabama | 79 | 79 | 0.2 |
| Alaska | 126 | 171 | 35.9 |
| Arizona | 90 | 89 | (0.4) |
| Arkansas | 75 | 77 | 1.3 |
| California | 111 | 110 | (0.7) |
| Colorado | 104 | 104 | 0.3 |
| Connecticut | 137 | 134 | (2.5) |
| Delaware | 103 | 103 | 0.8 |
| Florida | 96 | 90 | (6.5) |
| Georgia | 91 | 93 | 2.2 |
| Hawaii | 99 | 102 | 2.1 |
| Idaho | 77 | 77 | (0.4) |
| Illinois | 108 | 107 | (0.6) |
| Indiana | 91 | 91 | (0.8) |
| Iowa | 93 | 92 | (1.4) |
| Kansas | 99 | 99 | 0.0 |
| Kentucky | 79 | 82 | 3.2 |
| Louisiana | 79 | 89 | 12.7 |
| Maine | 88 | 87 | (1.8) |
| Maryland | 115 | 106 | (7.6) |
| Massachusetts | 124 | 120 | (2.8) |
| Michigan | 103 | 100 | (2.6) |
| Minnesota | 102 | 102 | 0.5 |
| Mississippi | 68 | 70 | 2.8 |
| Missouri | 96 | 96 | (0.3) |
| Montana | 83 | 85 | 3.2 |
| Nebraska | 93 | 95 | 1.7 |
| Nevada | 96 | 101 | 4.8 |
| New Hampshire | 111 | 106 | (4.6) |
| New Jersey | 132 | 126 | (4.6) |
| New Mexico | 77 | 84 | 8.7 |
| New York | 117 | 119 | 1.1 |
| North Carolina | 85 | 88 | 3.7 |
| North Dakota | 88 | 91 | 3.2 |
| Ohio | 96 | 96 | (0.3) |
| Oklahoma | 86 | 88 | 2.1 |
| Oregon | 89 | 88 | (1.0) |
| Pennsylvania | 99 | 95 | (4.6) |
| Rhode Island | 101 | 96 | (5.3) |
| South Carolina | 77 | 77 | (1.0) |
| South Dakota | 82 | 81 | (1.1) |
| Tennessee | 83 | 85 | 2.2 |

ATTACHMENT I

ATTACHMENT I

| State | Index No., U.S. = 100 Per Capita Income | Per Capita Taxable Resources | Percent Difference |
|---|---|---|---|
| Texas | 92 | 98 | 7.1 |
| Utah | 75 | 79 | 4.9 |
| Vermont | 90 | 90 | 0.7 |
| Virginia | 105 | 103 | (1.4) |
| Washington | 98 | 97 | (0.8) |
| West Virginia | 75 | 76 | 0.3 |
| Wisconsin | 96 | 95 | (1.4) |
| Wyoming | 91 | 117 | 28.2 |

Note: Index numbers were rounded to the nearest whole number

ATTACHMENT II

ATTACHMENT II

COMPARISON OF PER CAPITA INCOME WITH POVERTY RATES

| State | Per Capita Income | Poverty Rate |
|---|---|---|
| Mississippi | $10,000 | 36.7% |
| Utah | 11,059 | 20.4 |
| West Virginia | 11,067 | 24.7 |
| Arkansas | 11,078 | 32.0 |
| Idaho | 11,337 | 23.8 |
| New Mexico | 11,345 | 29.6 |
| South Carolina | 11,347 | 27.1 |
| Alabama | 11,555 | 29.3 |
| Louisiana | 11,620 | 28.4 |
| Kentucky | 11,620 | 29.2 |
| South Dakota | 11,978 | 26.6 |
| Montana | 12,124 | 22.6 |
| Tennessee | 12,234 | 27.7 |
| North Carolina | 12,507 | 25.3 |
| Oklahoma | 12,668 | 22.5 |
| North Dakota | 12,873 | 22.8 |
| Maine | 12,943 | 25.0 |
| Oregon | 13,009 | 20.1 |
| Arizona | 13,142 | 22.6 |
| Vermont | 13,184 | 21.9 |
| Georgia | 13,363 | 26.9 |
| Indiana | 13,392 | 17.6 |
| Wyoming | 13,411 | 14.4 |
| Texas | 13,455 | 24.7 |
| Iowa | 13,616 | 16.8 |
| Nebraska | 13,676 | 19.1 |
| Ohio | 14,055 | 17.8 |
| Missouri | 14,074 | 22.1 |
| Wisconsin | 14,079 | 15.8 |
| Nevada | 14,127 | 16.1 |
| Florida | 14,150 | 22.8 |
| Washington | 14,416 | 18.0 |
| Kansas | 14,513 | 18.7 |
| Pennsylvania | 14,586 | 18.5 |
| Hawaii | 14,592 | 17.9 |
| Rhode Island | 14,892 | 18.7 |
| Minnesota | 14,908 | 17.0 |
| Michigan | 15,055 | 18.3 |
| Delaware | 15,068 | 20.3 |
| Colorado | 15,234 | 17.8 |
| Virginia | 15,367 | 19.4 |
| Illinois | 15,801 | 18.1 |
| California | 16,247 | 20.4 |
| New Hampshire | 16,333 | 16.8 |

ATTACHMENT II

ATTACHMENT II

| State | Per Capita Income | Poverty Rate |
|---|---|---|
| Maryland | 16,862 | 16.7 |
| New York | 17,214 | 22.1 |
| Massachusetts | 18,163 | 17.1 |
| Alaska | 18,499 | 16.7 |
| New Jersey | 19,302 | 16.6 |
| Connecticut | 20,157 | 14.5 |
| U.S. | $14,674 | 21.2% |

ATTACHMENT III

ATTACHMENT III

COMPARISON OF FEDERAL MEDICAID MATCHING PERCENTAGES UNDER THE CURRENT FORMULA AND A FORMULA USING (1) TOTAL TAXABLE RESOURCES, (2) POVERTY COUNTS, AND (3) A 40 PERCENT MINIMUM FEDERAL SHARE: FY 1989

| State | Federal Share | |
|---|---|---|
| | Current Formula | Alternative Formula |
| Alabama | 73% | 76% |
| Alaska | 50 | 40 |
| Arizona | N/A | N/A |
| Arkansas | 74 | 79 |
| California | 50 | 52 |
| Colorado | 50 | 49 |
| Connecticut | 50 | 40 |
| Delaware | 53 | 55 |
| Florida | 55 | 65 |
| Georgia | 63 | 70 |
| Hawaii | 54 | 50 |
| Idaho | 73 | 72 |
| Illinois | 50 | 48 |
| Indiana | 64 | 55 |
| Iowa | 63 | 52 |
| Kansas | 55 | 53 |
| Kentucky | 73 | 75 |
| Louisiana | 71 | 72 |
| Maine | 67 | 70 |
| Maryland | 50 | 44 |
| Massachusetts | 50 | 40 |
| Michigan | 55 | 52 |
| Minnesota | 53 | 47 |
| Mississippi | 80 | 83 |
| Missouri | 60 | 62 |
| Montana | 71 | 67 |
| Nebraska | 60 | 56 |
| Nevada | 50 | 45 |
| New Hampshire | 50 | 45 |
| New Jersey | 50 | 40 |
| New Mexico | 72 | 75 |
| New York | 50 | 53 |
| North Carolina | 68 | 69 |
| North Dakota | 67 | 65 |
| Ohio | 59 | 53 |
| Oklahoma | 66 | 65 |
| Oregon | 62 | 61 |
| Pennsylvania | 57 | 55 |
| Rhode Island | 56 | 55 |
| South Carolina | 73 | 75 |

ATTACHMENT III

ATTACHMENT III

| State | Federal Share | |
|---|---|---|
| | Current Formula | Alternative Formula |
| South Dakota | 71 | 73 |
| Tennessee | 70 | 73 |
| Texas | 59 | 65 |
| Utah | 74 | 66 |
| Vermont | 64 | 64 |
| Virginia | 51 | 53 |
| Washington | 53 | 52 |
| West Virginia | 76 | 73 |
| Wisconsin | 59 | 47 |
| Wyoming | 63 | 40 |

ATTACHMENT IV ATTACHMENT IV

COMPARISON OF FEDERAL MEDICAID ASSISTANCE UNDER THE CURRENT FORMULA AND A FORMULA USING (1) TOTAL TAXABLE RESOURCES, (2) POVERTY COUNTS, AND (3) A 40 PERCENT MINIMUM FEDERAL SHARE: FY 1989 (millions of dollars)

| State | Federal Aid: Current Formula | Federal Aid: Alternative Formula | Difference | Percent Difference |
|---|---|---|---|---|
| Alabama | $408.5 | $488.7 | $80.2 | 19.6% |
| Alaska | 74.1 | 44.8 | (29.3) | (39.6) |
| Arizona | N/A | N/A | N/A | N/A |
| Arkansas | 395.3 | 535.7 | 140.4 | 35.5 |
| California | 3,233.7 | 3,519.7 | 286.0 | 8.8 |
| Colorado | 268.5 | 234.6 | (33.9) | (12.6) |
| Connecticut | 532.8 | 346.1 | (186.7) | (35.0) |
| Delaware | 63.1 | 69.4 | 6.3 | 9.9 |
| Florida | 1,133.4 | 1,711.2 | 577.8 | 51.0 |
| Georgia | 823.4 | 1,118.4 | 295.0 | 35.8 |
| Hawaii | 104.8 | 88.9 | (15.9) | (15.2) |
| Idaho | 101.6 | 99.5 | (2.1) | (2.1) |
| Illinois | 1,132.5 | 1,028.1 | (104.4) | (9.2) |
| Indiana | 772.1 | 531.2 | (240.9) | (31.2) |
| Iowa | 353.1 | 227.0 | (126.1) | (35.7) |
| Kansas | 222.6 | 205.8 | (16.8) | (7.5) |
| Kentucky | 621.8 | 722.8 | 101.0 | 16.2 |
| Louisiana | 840.1 | 918.6 | 78.5 | 9.4 |
| Maine | 254.2 | 293.7 | 39.5 | 15.5 |
| Maryland | 534.1 | 407.3 | (126.7) | (23.7) |
| Massachusetts | 1,232.4 | 795.8 | (436.6) | (35.4) |
| Michigan | 1,273.4 | 1,090.2 | (183.3) | (14.4) |
| Minnesota | 706.6 | 551.1 | (155.5) | (22.0) |
| Mississippi | 415.2 | 535.2 | 120.0 | 28.9 |
| Missouri | 515.6 | 542.8 | 27.1 | 5.3 |
| Montana | 124.5 | 106.7 | (17.8) | (14.3) |
| Nebraska | 177.3 | 149.9 | (27.5) | (15.5) |
| Nevada | 59.9 | 47.5 | (12.4) | (20.7) |
| New Hampshire | 105.5 | 82.9 | (22.6) | (21.5) |
| New Jersey | 1,043.8 | 678.2 | (365.6) | (35.0) |
| New Mexico | 189.0 | 225.1 | 36.0 | 19.1 |
| New York | 5,635.7 | 6,314.5 | 678.8 | 12.1 |
| North Carolina | 837.4 | 903.8 | 66.5 | 7.9 |
| North Dakota | 121.8 | 115.9 | (5.8) | (4.8) |
| Ohio | 1,656.9 | 1,274.9 | (382.0) | (23.1) |
| Oklahoma | 461.8 | 453.4 | (8.3) | (1.8) |
| Oregon | 308.1 | 305.9 | (2.2) | (0.7) |
| Pennsylvania | 1,652.6 | 1,503.2 | (149.4) | (9.0) |
| Rhode Island | 217.0 | 205.4 | (11.5) | (5.3) |
| South Carolina | 442.5 | 509.8 | 67.3 | 15.2 |

ATTACHMENT IV

ATTACHMENT IV

| State | Federal Aid: Current Formula | Federal Aid: Alternative Formula | Difference | Percent Difference |
|---|---|---|---|---|
| South Dakota | 106.1 | 115.2 | 9.0 | 8.5% |
| Tennessee | 824.7 | 959.9 | 135.2 | 16.4 |
| Texas | 1,426.2 | 1,811.0 | 384.7 | 27.0 |
| Utah | 171.7 | 122.6 | (49.1) | (28.6) |
| Vermont | 92.9 | 90.0 | (2.9) | (3.1) |
| Virginia | 458.5 | 488.7 | 30.2 | 6.6 |
| Washington | 570.3 | 545.2 | (25.0) | (4.4) |
| West Virginia | 271.7 | 246.1 | (25.6) | (9.4) |
| Wisconsin | 781.7 | 481.6 | (300.1) | (38.4) |
| Wyoming | 37.3 | 14.3 | (23.0) | (61.7) |
| Total Redistributed | | | $3,159.5 | 17.0% |

Mr. WEISS. I assume that your colleagues are there to respond to questions also?

Ms. SHIKLES. Yes, sir.

Mr. WEISS. Your entire prepared statement will be entered into the record as well as the GAO report upon which it is based.

Some of my questions may, in fact, be redundant, but I hope you will bear with me so that I can have a full understanding.

You have testified that the Medicaid funding formula is unfair because it doesn't accurately reflect poverty in each State; is that correct?

Ms. SHIKLES. That is correct.

Mr. WEISS. The formula is also unfair because it doesn't accurately measure tax capacity or the ability to fund Medicaid for each State; is that right?

Ms. SHIKLES. That is correct.

Mr. WEISS. The use of per capita income to measure the tax capacity of the States is the main reason for the unfairness in the formula.

Can you explain why per capita income is such a poor criteria?

Ms. SHIKLES. When they were first considering a formula to use, it was reasonable to use per capita income because it was probably the best available indicator of State needs at the time. Now we have better measures that would address the objectives of the Medicaid program. One of the problems with per capita income is that it only measures some of the taxing capacity of a State. States with a disproportionate share of business income are able to tax that, and it is not reflected in the per capita income. Consequently some States end up getting a lower Federal share under Medicaid than they should and others a higher share.

Another problem is that per capita income doesn't track very well with the State poverty rates. It is basically an average of income, so if you have a State that has very skewed income distribution, it will raise the average income and yet the Governor of the State is still faced with trying to pay for services of a high number of poor people.

Mr. WEISS. As an example of how inaccurate per capita income is in predicting poverty, you attached a table that compares State income averages with their poverty rates.

For instance, Arkansas and Utah have the same average per capita income, but Arkansas' poverty rate is 50 percent higher than Utah's.

Ms. SHIKLES. That is correct.

Mr. WEISS. As a result of this inequity, are some States receiving less in Federal assistance than they would if the formula accurately measured poverty and tax capacity?

Ms. SHIKLES. That is correct.

Mr. WEISS. Has this unfairness forced States with large poverty populations to limit the services that they provide to needy patients?

Ms. SHIKLES. It is probably a major contributing factor.

The studies and our research have shown that States that have low income, low taxing capacity and high numbers of poor have tended to finance generally much more limited Medicaid programs.

There are other factors, though, political, social factors, that also come into play.

For example, you have Texas and New York, which both face an above-average tax burden in financing coverage for the poor and yet New York provides a very generous Medicaid program and Texas has a much more limited program.

So you can't totally attribute the problem to the formula because there are other considerations, but it is certainly a major consideration.

Mr. WEISS. How much did you find that States differed in their coverage of the poverty populations?

Ms. SHIKLES. There is a very wide variation across the States.

Mr. FASTRUP. In the data we have looked at, the biggest difference occurs between Idaho and Michigan.

Idaho's coverage of low-income people is a little bit less than half the national average, somewhere around 45 percent, whereas Michigan's coverage is, I think, over 1½ times the national average.

So there is a 3 to 1 disparity between the two States in terms of coverage of their low-income residents.

Mr. WEISS. Did you find that the States with the greatest number of poor people also spend the least on Medicaid?

Ms. SHIKLES. There are some exceptions, but that is generally true.

Mr. WEISS. Do you believe that the unfairness of the formula contributes to this problem?

Ms. SHIKLES. I think that is certainly an important factor, although there are also political considerations.

Mr. WEISS. You indicated that the Medicaid patients in the poorer States are losing $3.2 billion in Federal assistance to the needy because of the unfairness of the formula; is that correct?

Ms. SHIKLES. That is based on our recalculations of Federal matching percentages using poverty and total taxable resources. This set of States would have received about $3.2 billion more.

Mr. FASTRUP. Our analysis was done with the assumption of allocating the same amount of money the Federal Government provided in fiscal year 1989. We found about $3.2 billion or 17 percent of the funds would be redistributed.

That doesn't necessarily mean that if the formula were changed that this is what would actually happen, that depends on other factors affecting funding under the formula. For example, whether or not the Federal Government was going to make a change that was budget-neutral, or whether the Federal Government was going to contribute some additional funding to improve the equity of the formula.

Mr. WEISS. In States that spend about the same per person on Medicaid, does the unfairness in the formula result in some States spending less of their tax bases on Medicaid than others?

Ms. SHIKLES. Yes.

The States that have higher resources and fewer poor people can do so with a much lower burden on State taxpayers.

Mr. WEISS. I gather, again looking at the appendix material that you have, that Florida, for example, would have to expend twice

the tax effort as Connecticut to finance the same spending per person on Medicaid; is that correct?

Mr. FASTRUP. That is true.

The analysis answers the following question: If States were to provide the national average of funding per person in poverty, what tax effort would be required?

We found that Florida would have to expend a tax effort that is roughly twice that of Connecticut to provide the same level of spending per person in poverty.

Mr. WEISS. There are also major differences in the amounts spent per patient by the States, ranging from $1,290 in Mississippi to $5,792 in New Hampshire.

Is that correct?

Ms. SHIKLES. Yes; that is correct.

Mr. WEISS. What is the national average—do you have that number?

Mr. FASTRUP. I don't have that number right at my fingertips.

Mr. WEISS. We have an indication that it is $2,716.

Ms. SHIKLES. I believe that is correct.

Mr. WEISS. You have testified that the current Medicaid funding formula is unfair because it uses per capita income to measure needs and tax capacity.

When the formula was adopted 25 years ago, I gather that may have been the best way to measure needs and ability to pay.

Today, are there better methods to measure poverty and tax capacity, and if so, which method would you recommend?

Ms. SHIKLES. We believe that there are better measures that could be used and should be considered by the Congress, as said in my statement.

Certainly, we would recommend for your consideration incorporating the number of poor people per State, and considering a measure of States ability-to-pay for services such as TTR.

The Advisory Commission on Intergovernmental Relations also has developed a measure which could be considered.

We would also recommend that we need current poverty data and the Census could provide that, so that that would be more sensitive to the States' needs, by being updated annually for changes in States' poverty populations.

Mr. WEISS. The TTR measures what?

Ms. SHIKLES. All the taxing resources within a State. Per capita income is just a more limited measure that only measures average income to a State resident. A lot of business income is not included in that figure, which the TTR does reflect.

So that is why Treasury and the Department of Commerce now calculate different measures, and that is why Congress is now using TTR in place of per capita income in distributing the ADAMHA block grant funds.

Mr. WEISS. I thank you very much for your testimony.

Please express my appreciation to GAO generally for the tremendous work that they have done on this particular project.

Ms. SHIKLES. Thank you very much.

Mr. WEISS. Is Ms. Wilensky here?

I think we will move at this point to a witness from the American Association of Retired Persons, Ms. Madge Eddy Boardman; and Sara Rosenbaum, Children's Defense Fund.

Your prepared statements will be entered in the record in their entirety and you may proceed as you feel most appropriate.

## STATEMENT OF MADGE EDDY BOARDMAN, AMERICAN ASSOCIATION OF RETIRED PERSONS

Ms. BOARDMAN. Thank you very much. Thank you, Mr. Chairman.

I am Madge Boardman, Vermont State Vote Board coordinator for the American Association of Retired Persons. The association welcomes this opportunity to discuss the need for health care for Americans of all ages and incomes and our concerns about the Medicaid program. We commend you and members of this subcommittee for focusing on these important issues.

Medicaid is intended to serve as the health safety net for our Nation's impoverished citizens. As the major source of funding health care for poor and low-income persons, it is—for better or worse—a symbol of America's commitment to provide for its most vulnerable people. But increasingly Medicaid coverage is an illusion of protection, and increasingly Medicaid expansions are hollow promises.

Although Medicaid provides essential benefits to millions of Americans, it is a program with many limitations. Our testimony will discuss these limitations along with recent improvements in the program and additional steps that need to be taken. No matter how many incremental improvements are made, however, the Medicaid program cannot be expected to serve the full range of health care problems experienced by low-income Americans. Ultimately, access to basic health and long-term care services is a broader problem which cries out for a broader solution.

AARP has long supported a comprehensive approach to providing affordable, quality health and long-term care to Americans of all ages and incomes, an approach which would address both the cost of health care and access to that care. Such a reformed system would shift our public commitment to providing health care away from the welfare approach and toward one that is based on, though perhaps not exclusive in its reliance upon social insurance—much like our Social Security and Medicaid programs.

The association recognizes and accepts that incremental steps may be necessary to move this country toward the broader goal. But the architectural blue print, the broad design for ultimate system reform should determine the approach necessary in each step.

For those whom it covers, the Medicaid program significantly reduces out-of-pocket expenditures for health care. Many low-income people, however, do not receive Medicaid benefits. In 1987, Medicaid covered only 42 percent of Americans with incomes below the Federal poverty line.

I might depart from the text here and say that of all the valuable information I have received through my experiences with AARP, this was the most gripping and shocking piece of information that I have found.

These low participation rates are the product of a number of serious limitations of the Medicaid program. Let me outline these for you.

First, Medicaid eligibility rules exclude many groups from Medicaid coverage. For example, completely excluded from the program no matter how poor are single people and childless couples who are under 65 and do not meet the disability tests. That is another fact that is incredible to me.

Second, the income standards which States set vary greatly from State to State.

Third, the stigma and administrative barriers associated with applying for such welfare benefits impede participation in the Medicaid program.

Fourth, low reimbursement to providers limits the availability of Medicaid providers in a community. This in turn creates access problems for Medicaid recipients.

This can happen in a rural area, and I am from Vermont—sometimes individuals forgo care all together or they may use hospital out-patient and emergency room services more often, an expensive outcome.

Fifth, Medicaid costs, like other health care costs, are skyrocketing and placing great burdens on the Federal and State budgets. Regrettably, rather than addressing the root causes of increasing costs, many States have cut back on services.

Increasing costs also threaten the prospect for program expansions nationwide. The fact that Medicaid costs are rising cannot be used as an excuse not to provide health care. Rather, this dilemma should push us toward a universal comprehensive system that can control costs and provide quality care, and I know those questions are coming, Mr. Chairman.

Finally, Medicaid has become the Government's primary means of paying for long-term care. Long-term care is the single largest component of Medicaid budgets.

Given demographic trends, the increasing bite that such care takes out of Medicaid budgets will make it even more difficult to provide needed health care to low-income persons.

The onerous spend-down process is badly flawed. It destroys rather than protects financial independence. It assumes responsibility for care after the fact rather than encouraging coordinated care. And it is biased toward institutional care rather than more desirable and appropriate home and community-based options.

Unless and until we create a social insurance program like Medicare to provide long-term care for all Americans, Medicaid spending on long-term care will continue, and needed expansions for younger populations could be delayed or denied. This is an unacceptable choice.

In recent years, Congress enacted several Medicaid improvements which AARP has strongly supported. These improvements have focused on expanding eligibility for pregnant women and young children, and on increasing protection against the out-of-pocket costs of Medicare for older Americans.

AARP has supported and applauds these major expansions. The association is also pleased that OBRA 1990 began to address the institutional bias in the Medicaid program by providing States with

the option of offering home and community-based services to frail elderly populations.

Finally, OBRA 1990 included a provision requiring the Department of Health and Human Services to implement beneficiary assistance programs, which include information and counseling about the Medicaid program.

In our State of Vermont, we participated in AARP's pilot project to offer outreach information and consultation to encourage greater participation in the SSI program, and in some communities we made significant gains through that, and AARP would like to see that replicated with respect to Medicaid.

For many years, the association has sought to improve access to health care services for the underserved through legislation that is targeted to those most in need. While these steps alone are no longer adequate because they do not address the systemwide problems with health care coverage in this country, this strategy has had important successes.

The association continues its support for expansions in the Medicaid program as the most likely short-term opportunity to ensure that poor persons, regardless of their age or circumstance, have health insurance coverage.

Other incremental steps that the association supports to improve the Medicaid program include deeming all people living at or below the Federal poverty line to be eligible for Medicaid, requiring all States to have medically needy programs for people of all ages, and adjusting Medicaid reimbursement to make it fair to providers, and I would like to add as the fourth, greater outreach, as with SSI.

The Medicaid program is the centerpiece of America's commitment to provide health care to its low-income citizens. Yet, despite our Nation's wealth and social conscience, we have fallen far short of meeting the most basic health care needs of our people. We are currently at a major historical crossroads where we must decide which course to take: Continue our failed, disjointed incremental approach, based on an outmoded welfare model, or take bold action to enact comprehensive reform to ensure access, quality and cost containment.

In the association's view, the answer must lie in a comprehensive approach that recognizes the complexity of the system and interdependence among its many parts. The answer must lie in a comprehensive health care system that provides affordable, long-term health care to all Americans.

If we continue to rely on Medicaid to provide health care for millions of poor and low-income Americans and to provide long-term care to the disabled, we will be relying on a hollow promise.

AARP has undertaken major public education efforts to explain the crisis in our health care system to our members and to all Americans. Reform will only be possible as the American people understand both benefits and costs, the risks of inaction and the opportunities of comprehensive reform.

We look forward to working with this committee and the Congress as this debate proceeds. Thank you very much for listening.

[The prepared statement of Ms. Boardman follows:]

Bringing lifetimes of experience and leadership to serve all generations.

TESTIMONY OF THE

THE

AMERICAN ASSOCIATION OF RETIRED PERSONS

Regarding

**THE MEDICIAD BUDGET CRISIS**

Before the

SUBCOMMITTEE ON HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS

OF THE

COMMITTEE ON GOVERNMENTAL OPERATIONS

U.S. HOUSE OF REPRESENTATIVES

DECEMBER 7, 1990

Presented by: Madge Eddy Boardman
AARP-VOTE Coordinator
for
Vermont

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Thank you, Mr. Chairman. I am Madge Eddy Boardman, Vermont VOTE Coordinator for the American Association of Retired Persons (AARP). I am from Stowe, Vermont. The Association welcomes the opportunity to discuss the challenges concerning the Medicaid program and health care for low-income citizens. We commend you and members of this Subcommittee for focusing on these important issues.

Medicaid is intended to serve as the health care "safety net" for our nation's impoverished citizens. Over time it has also become the Federal government's primary means of providing long term care. As the major source of funding health care for poor and low-income persons, it is--for better or worse--a symbol of America's commitment to provide for its most vulnerable people.

Although Medicaid provides essential benefits to millions of Americans, it is a program with many limitations. These limitations have stood in the way of Medicaid fulfilling the promise of basic health care for low-income Americans of all ages. Our testimony will discuss these limitations, along with recent improvements in the program and additional steps that need to be taken. No matter how many incremental improvements are made, however, the Medicaid program cannot be expected to serve the full range of health care problems experienced by low-income

Americans. Ultimately, access to basic health and long-term care services is a broader problem which cries out for a broader solution.

We can be proud as a nation of our achievements in health care, but those achievements are diminished by our failure to guarantee access to basic medical and supportive care services for all citizens. Last year, approximately $600 billion was spent on health care in the United States. Yet, even though this represents more spending per capita and a higher proportion of the GNP than in any other country in the world, serious barriers to care exist.

- The cost of health care, which has risen at more than twice the rate of general inflation over the last decade, is a significant and growing barrier.

- Over 34 million Americans have no health insurance coverage, and millions more have inadequate protection.

- We have no system to assure access to or to pay the costs of long term care, forcing individuals to rely on Medicaid.

AARP has long supported a comprehensive approach to providing affordable, quality health and long term care to Americans of all ages and incomes. Such a reformed system would shift our public

commitment to providing health care away from a welfare approach and toward one that is based on, though perhaps not exclusively reliant upon, social insurance--much like our Social Security and Medicare programs. It will be very important that a new system also constrain costs and cost shifting and reduce the complexity and fragmentation of our current system.

The Association recognizes and accepts that incremental steps may be necessary to move this country toward the broader goal. But the "architectural blueprint"--the broad design--for ultimate system reform should determine the appropriateness of each step.

Public surveys indicate that Americans view health care as a right, and that the public overwhelmingly supports extending coverage to all uninsured people. Making the necessary changes in our health care system to provide acute, preventive and long term care services to all Americans, while restraining costs and improving the quality of care, is one of the major challenges for our nation in the 1990's.

THE HEALTH STATUS OF LOW INCOME AMERICANS

Despite our nation's wealth of resources, significant health-related problems for low-income persons persist. Poor health status, multiple chronic conditions and dependencies in basic activities of daily living (ADLs) are all more prevalent among

low-income persons than among those with higher incomes. Among the population over 65 years of age, for example, 47 percent of those who are poor (with incomes below the Federal poverty level $6,280 in 1990) and 37 percent of those with incomes between 100 and 200 percent of the Federal poverty level, report their health as fair or poor, while 25 percent of those older Americans with incomes over 200 percent of poverty express similar views.

Studies have shown that the occurrence of such conditions as arthritis, hypertension, heart disease, cerebrovascular disease, diabetes, vision, and hearing problems is consistently higher among the poor elderly than among those who are not poor. In addition, while 12 percent of the non-poor elderly report being restricted in one or more ADLs (e.g., eating, dressing, toileting, etc.), 21 percent of poor elderly people report having such limitations. Similar problems exist for poor children, who are more likely to have a variety of health problems (e.g. low birth weight, hearing disorders, poor vision, iron deficiency anemia) than non-poor children. In sum, low-income persons are more likely to experience health problems and need medical and other health-related services, but are less able to afford them.

LIMITATIONS OF THE MEDICAID PROGRAM

For those whom it covers, the Medicaid program significantly reduces out-of-pocket expenditures for health care. For

instance, in 1989, the poor elderly covered by Medicaid had out-of-pocket health care expenses of $287 (excluding long term care) while average expenditures exceeded $1,000 for poor elderly persons without Medicaid coverage.

Many low-income people, however, do not receive Medicaid benefits. In 1987 Medicaid covered only 42 percent of Americans with incomes below the federal poverty line. Among the elderly, only 29 percent of the poor and 10 percent of those with incomes between 100 and 200 percent of poverty have Medicaid coverage. These low participation rates are the product of a number of serious limitations of the Medicaid program. Some of these limitations relate to categorical restrictions on eligibility, services and provider reimbursement imposed by the federal and state governments; others result from a reluctance on the part of those who need services to participate in Medicaid because of the stigma associated with welfare programs. A discussion of some of the most serious limitations of the Medicaid program follows.

1.) Exclusions of Major Populations--Federal law limits Medicaid coverage to actual or potential receipt of cash assistance under the Aid to Families with Dependent Children program (AFDC) and the Supplemental Security Income program (SSI). Thus, completely excluded from the program, no matter how poor, are single people and childless couples who are under 65 and do not meet the disability tests.

2.) Variations in State Eligibility Standards--Within the categories of eligibility permitted under law, states have great discretion in setting income ceilings for Medicaid coverage. Further exacerbating these disparities is the fact that many states do not adequately adjust their standards to reflect inflation, making the eligibility levels even more restrictive over time.

Thirty-five states have attempted to address some of these problems through "medically needy" programs, whereby people with somewhat higher incomes may become Medicaid eligible if they have medical expenses that reduce their incomes to below the states' medically needy income levels. This process is commonly referred to as "spend-down." The medically needy levels, however, tend to be lower than the general Medicaid eligibility levels for the elderly and disabled.

3.) Welfare Stigma and Administrative Barriers--Other factors which impede participation in the Medicaid program are the stigma and administrative barriers associated with applying for such welfare benefits. The Commonwealth Fund Commission on Elderly People Living Alone has estimated that one-half of those potentially eligible for SSI and Medicaid program benefits fail to enroll. The two major reasons for this underenrollment appear to be a reluctance to depend on a welfare program and a lack of knowledge of the Medicaid program and its benefits.

4) Reimbursement and Provider Participation--Problems regarding eligibility and coverage do not fully explain the substantial limitations of the Medicaid program. Access also requires that physicians and other providers be available in the community and willing to see the Medicaid patient. Medicaid reimbursement to providers is one factor in their availability. In addition to creating serious access problems for Medicaid patients, low reimbursement rates also often force providers who do take Medicaid patients to shift costs onto private pay patients. It also appears that the low fee levels may mean less use of office-based services, with offsetting increases in the use of hospital outpatient departments and emergency rooms--an outcome which is expensive and places an unwarranted burden on these facilities.

5) Medicaid And State Budgets--Medicaid improvements and, therefore, health care access for America's poor, are increasingly dependent upon state budgets. Currently, in this joint state-federal program, the federal share of costs averages 55 percent, but ranges from 50 to approximately 80 percent. It is estimated that in 1990, states will spend $25.2 billion to cover 22 million Medicaid recipients, with the federal share totaling $35.1 billion. The contribution or "state match" formula is inversely proportional to state per capita income with poorer states getting a higher federal matching rate. Along with education and prisons, spending on Medicaid has become one of the largest components of state budgets. According to the National

Conference of State Legislators, Medicaid spending currently absorbs about 9 percent of state general funds per year.

Cost increases in the Medicaid program mirror increases elsewhere in the health care sector, but they also point to the program's inability to effectively keep health care costs under control. The fact that program costs are rising cannot be used as an excuse not to provide health care; rather, this dilemma should push us toward a universal, comprehensive system that can control costs and provide quality health care to all Americans.

6.) Expenditures for Nursing Home Care For Older Americans --When the Medicaid program was enacted, it was not anticipated that it would become the primary third-party payer for nursing home care. Yet now, 25 years later, nursing home care is the single largest component of Medicaid budgets, absorbing over one-third of total Medicaid expenditures. Given trends on the demographics of aging, the increasing bite that such care takes out of Medicaid budgets will make it even more difficult to expand needed care to other populations and for other services. The onerous spend-down process is badly flawed: it destroys rather than protects financial independence, it assumes responsibility for care after the fact rather than encouraging coordinated care, and it is biased toward institutional care rather than more desirable and appropriate home and community-based options. But unless and until we expand federal coverage for this care, Medicaid spending

on the elderly will continue to increase and needed extensions to younger populations could be delayed or denied. This is an unacceptable choice.

In general, individuals pay for nursing home care out of their own pockets until they exhaust their savings sufficiently to qualify for Medicaid coverage. Forty-eight percent of nursing home costs are paid for out-of-pocket and 44 percent are paid for by the Medicaid program. This reliance by individuals upon Medicaid to pay their long-term care bills is a major factor in the escalating rate of Medicaid spending. To the degree that the federal government, through Medicare or a similar social insurance program, can expand coverage to long term care, the state Medicaid burden in paying for these services can be reduced.

RECENT FEDERAL INITIATIVES

In recent years Congress has enacted several Medicaid improvements which AARP has strongly supported. These improvements have focused on expanding eligibility for pregnant women and young children, and on increasing protection against the out-of-pocket costs of Medicare for low-income older Americans. Since 1987, consistent progress has been made to extend mandatory coverage for children with families below the poverty line. Most recently, OBRA '90 required states to phase

in coverage, by the year 2002, for all children under age 19, born after September 3, 1983, in families with incomes at or below 100 percent of federal poverty.

Building on a 1988 law that required Medicaid to pay for Medicare deductibles, coinsurance and premiums for poor Medicare beneficiaries--the "Qualified Medicare Beneficiaries" (QMBs) program--OBRA '90 also accelerated the implementation of this requirement from 1992 to 1991 and further required that, effective in 1993, Medicaid will begin paying the Medicare Part B premium for beneficiaries with incomes between 100 and 120 percent of poverty; effective in 1995, this protection against the cost of the premium expands to include those with incomes between 100 and 120 percent of poverty.

The Association is also pleased that OBRA '90 began to address the institutional bias in the Medicaid program by providing states with the option of offering home and community-based services to the frail elderly population. Previously, states could provide these services under Medicaid only after obtaining a restrictive federal waiver. We are concerned, however, that the new program contains eligibility and funding restrictions which seriously limit its usefulness.

Finally, OBRA '90 included a provision requiring the Department of Health and Human Services to implement beneficiary assistance

programs, which include information and counseling about the Medicaid program. We believe such outreach to be essential and urge prompt and full implementation of this requirement.

The Need for Medicaid Reforms

For many years the Association has sought to improve access to health care services for the underserved through legislation that is targeted to those most in need. While these steps alone are no longer adequate because they do not address the system-wide problems with health care coverage in this country, this strategy has had important successes. The Association continues its support for expansions in the Medicaid program as the most likely short-term opportunity to ensure that poor persons, regardless of their age or circumstances, have health insurance coverage. In recent years this has meant our strong support for a number of initiatives, including:

- expanded Medicaid coverage of pregnant women and children;
- the Medicaid buy-in to Medicare for the poor and those just above the Federal poverty line; and
- legislation to make the home and community-based waiver program an option for the states.

The Association also supports the following incremental steps to improve the Medicaid program:

- o Deeming all people living at or below the federal poverty line to be eligible for Medicaid, without regard to their eligibility for government cash assistance programs. States should have the option to exceed the minimum standard and to phase-in increases in the eligibility level.
- o Requiring all states to have medically needy programs for people of all ages.
- o Adjusting Medicaid's fee schedule to provide fair reimbursement and thereby help ensure adequate access to the services of primary care physicians and specialists and other Medicaid providers.
- o Increasing the "personal needs allowance" for Medicaid nursing home residents and adjusting it thereafter according to changes in the cost-of-living.
- o Improving and updating Medicaid data collection in a broad spectrum of areas.

Conclusion

The Medicaid program is the centerpiece of America's commitment to provide health care to its low-income citizens. Yet, despite our nation's wealth, we have fallen far short of meeting the most basic health care needs of our people. We are currently at a major historical crossroads where we must decide which course to take: continue our failed disjointed, incremental approach based on an outmoded welfare model, or take bold action to enact

comprehensive reform to ensure access, quality and cost containment. In our view, the answer must lie in a comprehensive approach that recognizes the complexity of the system and the interdependence among its many parts, including both the way in which health care services are delivered and how such services are priced and financed.

AARP will continue and increase its public education efforts to help explain this crisis that can only intensify as health care costs rise, as the number of the uninsured and underinsured Americans grows, and as the population ages. Reform of our health care system will only be possible as the American people understand both benefits and costs, the risks of inaction, and the opportunities in comprehensive reform. We are confident that these questions will be answered in the form of clear and strong messages to our elected officials. Public education activities in the community and involvement in 1992 presidential elections offer excellent opportunities for public debate about these important questions.

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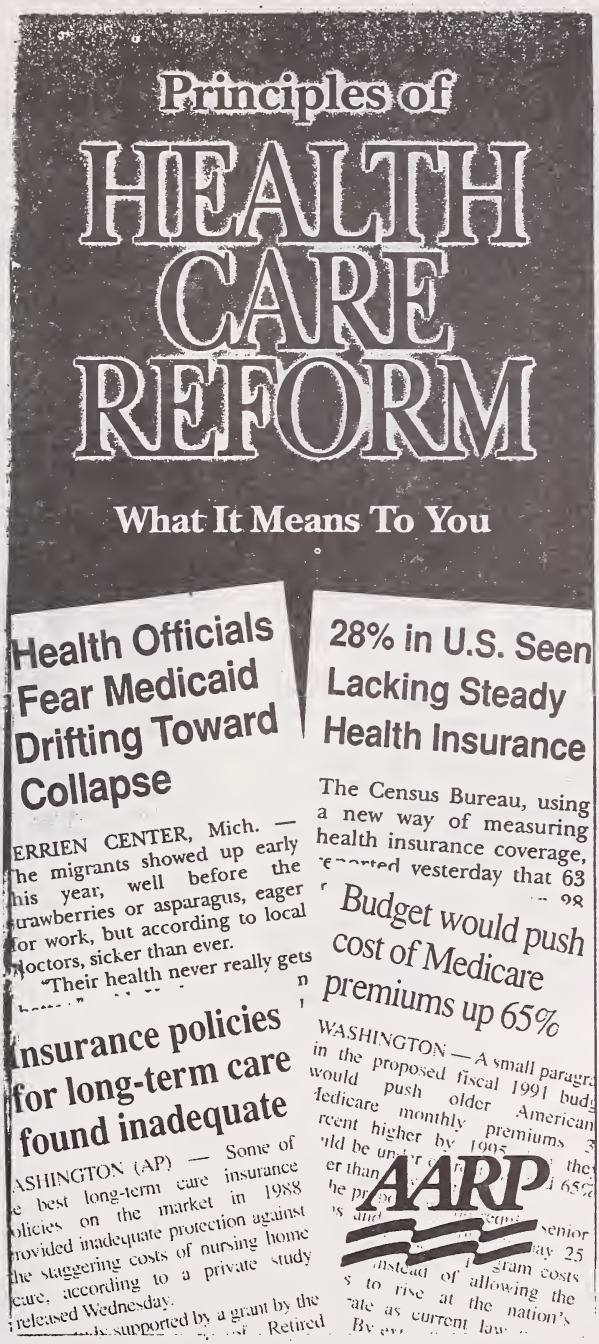


Principles of

# HEALTH CARE REFORM

What It Means To You

## Health Officials Fear Medicaid Drifting Toward Collapse

ERRIEN CENTER, Mich. — he migrants showed up early his year, well before the trawberries or asparagus, eager for work, but according to local doctors, sicker than ever.

"Their health never really gets

## Insurance policies for long-term care found inadequate

ASHINGTON (AP) — Some of e best long-term care insurance olicies on the market in 1988 rovided inadequate protection against the staggering costs of nursing home care, according to a private study released Wednesday.

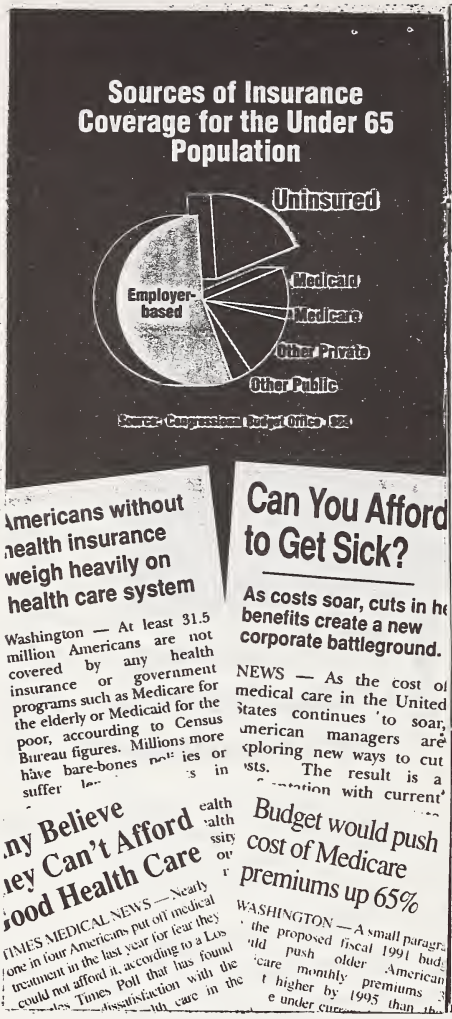
supported by a grant by the Retired

## 28% in U.S. Seen Lacking Steady Health Insurance

The Census Bureau, using a new way of measuring health insurance coverage, reported yesterday that 63

## Budget would push cost of Medicare premiums up 65%

WASHINGTON — A small paragra in the proposed fiscal 1991 budg would push older American Medicare monthly premiums 3 ercent higher by 1995 the uld be under er than i 65% he pr s and senior ay 25 instead of allowing the rate as current law


Sources of Insurance Coverage for the Under 65 Population
Uninsured
Employer-based
Medicaid
Medicare
Other Private
Other Public
Source: Congressional Budget Office, CBO
Americans without health insurance weigh heavily on health care system
Washington — At least 31.5 million Americans are not covered by any health insurance or government programs such as Medicare for the elderly or Medicaid for the poor, accourding to Census Bureau figures. Millions more have bare-bones
suffer
Can You Afford to Get Sick?
As costs soar, cuts in he benefits create a new corporate battleground.
NEWS — As the cost of medical care in the United States continues to soar, merican managers are xploring new ways to cut sts. The result is a
with current
ny Believe ey Can't Afford ood Health Care
IMES MEDICAL NEWS — Nearly one in four Americans put off medical treatment in the last year for fear they could not afford it, according to a Los Times Poll that has found
Budget would push cost of Medicare premiums up 65%
WASHINGTON — A small paragra the proposed fiscal 1991 budg uld push older American care monthly premiums t higher by 1995 than th e under curr

# Skyrocketing health care costs are taking a tragic toll on millions of Americans.

What if you were not in good health. What if you were in an accident? What if your insurance or Medicare didn't cover all of your costs? Could you afford to spend $10,000 for a needed operation? What about $100,000?

Even if you have private insurance or Medicare, you may have to pay 20% or more of the total costs of your care. And hospital stays exceeding $1 million are not unheard of.

Few people can pay that much. For many, it is a terrible choice between their life savings and the saving of their life.

We're not talking only about accidents or emergencies. The routine costs of maintaining good health are rising out of reach for too many Americans. And millions of disabled and older people need long term care, which few can afford.

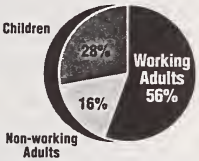
## It affects you.

Health care costs are out of control—out of reach from many Americans. In 1970, health care in the U.S. cost an average of $350 for each American. By 1988, it had shot up to $2124. And within ten years, this figure is expected to balloon to $6000! But what are we getting in return?

A serious illness can still leave you with thousands of dollars in medical bills, even if you have insurance. And even if you stay healthy, the soaring costs of health care may mean that your insurance premiums are eating up more and more of your budget. Plus employers faced with huge health care premiums may be forced to either reduce coverage or risk being forced out of business.

Even if you are covered by Medicare, that's no guarantee of protection. Medicare doesn't cover important health care services like prescription drugs and increasing medical costs can force cutbacks in Medicare coverage. Medigap premiums keep rising.

**The Uninsured Under 65 Population by Work Status**




Source: Employee Benefit Research Institute, March 1989 Current Population Survey

And what about those who have no health insurance at all—more than 34 million Americans younger than age 65. These aren't just the poor or unemployed either: About 85% of the uninsured are workers and their dependents. And millions more have inadequate health care insurance. When they can't pay, the costs are shifted to you through higher medical costs and insurance premiums.

## What if you or a loved one becomes chronically ill or disabled?

Few insurance plans provide for the long term care that almost every family will need to care for a sick or disabled loved one. These problems affect young and old alike—a grandparent with Alzheimer's disease ... a child with cerebral palsy, for example.

Almost none of the costs of long term care are covered by Medicare. And clearly health insurance alone does not protect you from the costs in time and money required to see you or a loved one through a serious illness.

## What's going to happen?

Never before have Americans spent so much on health care. And never before have Americans been so dissatisfied with their health care system. Clearly the situation has got to change. The only questions are how and when. Some members of Congress, governors and other public officials are advocating the need to reform our health care system to ensure that all Americans have access to basic health and long term care services.

AARP is concerned. We care about our members' concerns. And our members care about themselves and their younger families and friends. We think that America's health care system must be reformed. It simply must work better—for older people and for younger ones as well.

Our health care system can and must give us more health care value for our money. It can and must assure older people that they can pay for nursing home stays without being impoverished, and still get the nursing home care they need. And it can and must enable every man, woman and child to get needed health care.

AARP and its members will be active in the debate on health care reform proposals. And because you are so directly affected, it is vital for you to understand the issues of health care reform and what these proposals mean to you and your family.

## What can you do?

Health care reform will only happen after the American people understand the benefits and costs involved, and the risks of inaction. To aid this understanding, AARP has established ten principles to evaluate the fairness and adequacy of health care reform proposals. These principles can help set the standards for acceptable legislation in Congress.

As you consider these ten principles, think about the health care system you would like to be covered by. Ask yourself what health care benefits you most want. What are you willing to pay for them? What trade-offs are you willing to make to provide access to health and long term care for all Americans?

## Let us know what you think.

AARP always tries to represent the thinking of our members. We are seeking your input. We welcome your comments and suggestions, or if you would like to become involved please contact:

National Legislative Council
American Association of Retired Persons
Washington, DC 20049

# AARP's Ten Principles of Health Care Reform

**1. All individuals have a right to receive health care services when they need them.** The public, through the federal and state governments, has the ultimate responsibility to develop a system which ensures reasonable and equitable access to needed health care services for all individuals.

**2. All individuals have a right to reasonable access to health care coverage which provides adequate financial protection against health care costs.** The public, through the federal and state governments, has the ultimate responsibility to develop a system which ensures universal access to health care coverage for all individuals, including individuals with disabilities or health problems. The health care system should be designed to ensure that all individuals are covered by a public or private health coverage plan. The government should establish a minimum benefit package to which all individuals are entitled.

**3. All individuals have a right to high quality health care.** The health care system should collect, analyze, and disseminate information about provider performance, health care outcomes, and the appropriateness and effectiveness of health care services. Quality assurance programs, such as peer review and professional licensure, should be strengthened and coordinated.

**4. All individuals should have a reasonable choice of health care providers.** Cost containment efforts should not unreasonably limit choice of providers. Consumers should be provided with sufficient information about health care providers and treatment options to make informed health care decisions.

**5. Financing of the health care system should be equitable, broadly based and affordable to all individuals.** Government, employers, and individuals share the responsibility to participate in health care financing. Our present method of financing health care should be replaced by fairer, more progressive financing approaches. Burdensome cost-sharing requirements (e.g., burdensome deductibles and coinsurance) should be avoided because they disproportionately affect the sick and the poor. The public, through the federal and state governments, should subsidize the cost of health care coverage for individuals with lower incomes and should fully finance health care coverage for the poor. Any financing method should preserve the dignity of the individual, regardless of his or her income level.

**6. Methods of provider reimbursement should promote cost containment, encourage efficient service delivery, and compensate providers fairly.** Health care providers should receive basically the same reimbursement for the same services within a given area, regardless of the payment source. The government should play a major role in establishing more uniform reimbursement practices and rates for health care providers. Health care providers share in the responsibility to be fiscally prudent.

**7. Health care spending should be more rational and should be managed through more effective planning, budgeting, and resource coordination.** The distribution and allocation of health care resources (e.g., capital, technology, and personnel) should encourage innovation, efficiency, and cost effectiveness, and should promote reasonable access to services. Federal and state governments should play a major role in planning and coordinating the allocation of health care resources.

**8. All individuals have a right to a clean, healthy, and safe environment.** The public health system (e.g., water and sewer service, environmental protection, occupational safety, etc.) should be strengthened to ensure the public's health, safety, and well-being. Public health efforts should: (1) increase citizen understanding and awareness of health, environmental and safety issues and problems; (2) improve access to primary and preventive care services, such as maternal and child health care, immunizations, and nutrition counseling; (3) conduct health, environmental, and safety related research; (4) coordinate the collection and dissemination of information about health, environmental, and safety issues; and (5) assure compliance with health, environmental and safety standards.

**9. Individuals share a responsibility for safeguarding their health.** Individuals have a responsibility to educate themselves and take appropriate preventive measures to protect their health, safety, and well-being. The government, health care providers, and consumer organizations share in the responsibility to educate the public about health care.

Differentials in contributions for health care coverage to encourage healthy behavior can be appropriate as long as they do not deny access to health care.

**10. Long-term care should be provided to all individuals through a comprehensive public program based predominately on social insurance principles (e.g., Social Security).** Ultimately, the health care and long-term care financing and delivery systems should be integrated.

For more information on AARP's Long Term Care principles write:

National Legislative Council
American Association of Retired Persons
Washington, DC 20049

Mr. WEISS. Thank you very much, Ms. Boardman.

Sara Rosenbaum, director of the programs and policy division of the Children's Defense Fund.

## STATEMENT OF SARA ROSENBAUM, DIRECTOR, PROGRAMS AND POLICY DIVISION, CHILDREN'S DEFENSE FUND

Ms. ROSENBAUM. Thank you very much, Mr. Chairman.

As this subcommittee considers States' ability to finance Medicaid and reviews alternatives, the most important consideration should be the impact of financing arrangements on the populations who depend on the program. No population will be more affected by your work than women and children.

Persistently high childhood poverty rates, an eroding private health insurance system, and expansions enacted since 1984 have combined to make Medicaid an increasingly important source of third-party financing for maternity and pediatric care.

Right now we face a situation in which Medicaid is paying for about 40 percent of all births in the United States. In many States, that number has now surpassed 50 percent, not just 50 percent of all low-income births, but 50 percent of all births.

Even at the beginning of the decade, children were disproportionately dependent on Medicaid because of the absence of a private insurance and because of their higher poverty. Now that dependence has grown. The dependence has grown enough so that Medicaid now has the potential to influence not only poor children's access to care, but all children's access to care.

For example, in a State in which Medicaid funds literally half of all obstetrical beds, the program's underfunding and structural deficits ultimately are felt by all patients, not just those enrolled in the Medicaid program. The high volume of obstetrical care for which Medicaid is responsible today has caused numerous institutions around the country to close, curtail, or relocate their obstetrical services, either because of an insufficient number of physicians willing to admit or treat Medicaid patients, or because of very low reimbursement levels.

Similarly, in communities in which children's dependence on Medicaid is extremely high, it is very difficult to attract and retain private physicians. Children are extremely dependent at this point on the high-quality care provided by clinics and health centers established to provide comprehensive health care to the poor.

Unfortunately, there are only 550 federally funded health centers and far fewer county and local health departments with comprehensive primary health care programs.

There is nothing on the immediate horizon to suggest that children's dependence on Medicaid is going to decline. Poverty now claims 20 percent of all children, half of all black and Latino children, and more than a third of children living in families headed by someone under 30. As we head into another recession, it is undoubtedly true that child poverty is going to climb higher, and the number of children without private health insurance will grow. As a result, without some sort of national health reform, we are hopeful that Congress will continue as it has to continue to expand and strengthen the Medicaid program. At this point, however, we hope

that that effort will include not only expanded eligibility and benefits and improved reimbursement criteria, but also a federalization of the Medicaid program for children.

We are now in an era of State Medicaid cutbacks once again. States have many fewer options today than they had a decade ago when it comes to reducing care for pregnant women and children. Mandates that are now in place mean that all low-income young children will be covered by Medicaid. The benefit improvements enacted in 1989 go a long way toward stabilizing their access to preventive and primary benefits.

However, the reforms enacted to date have been limited. The reforms enacted a month ago to phase in coverage of poor children will proceed slowly, and for the children who even by a day exceed the age cutoff for the new benefits, the eligibility criteria are as low as 13½ percent of the Federal poverty level. Many children ages 8 and over face State Medicaid programs that exclude them with incomes as low as 20 percent of the Federal poverty level.

In addition, even though there now are more eligibility and benefit protections in place, the administration of a program like Medicaid is very complicated. States frequently fail to conform their programs to Federal requirements, which are very complicated. They may not understand them. They also may use benefit standards that are outdated and obsolete.

We have attached a letter from a community health center to the secretary of the State of Pennsylvania protesting the fact that in Pennsylvania right now, children enrolled in Medicaid are not able to get the four dosages of HIB vaccine that they need. The State covers only one dosage. That failure to cover all medically necessary HIB vaccine places the State out of compliance with Federal Medicaid law, but it is very difficult given the myriad issues the States grapple with as they administer Medicaid to assure that standards will be complied with.

The time simply has come to finish the job that was begun in the mideighties and to establish at least in the short term a unified nationally financed Federal Medicaid program that is administered in accordance with a single set of eligibility and benefit standards, a single set of standards governing the medial content and appropriateness of care, and which is subject to single standard quality control mechanisms.

Thank you very much.

Mr. Weiss. Thank you very much, Ms. Rosenbaum.

[The prepared statement of Ms. Rosenbaum follows:]

**Children's Defense Fund**

122 C Street, N.W.
Washington, D.C. 20001

Telephone (202) 628-8787

TESTIMONY OF THE CHILDREN'S DEFENSE FUND BEFORE THE COMMITTEE ON GOVERNMENT OPERATIONS, SUBCOMMITTE ON HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS, REGARDING THE ABILITY OF STATE GOVERNMENTS TO FUND MEDICAID

Presented by

Sara Rosenbaum

Director, Programs and Policy

December 7, 1990

Mr. Chairman and Members of the Subcommittee:

The Children's Defense Fund (CDF) appreciates this opportunity to testify today on the ability of state governments to adequately fund Medicaid and the impact of inadequate funding on the millions of women and children who depend on the program. The Children's Defense Fund is a national public charity which provides long range and systematic advocacy on behalf of low income, minority and disabled children. Since 1973 CDF has engaged in ongoing efforts to assure access to high quality, comprehensive health care for pregnant women and children.

As this Subcommittee considers States' ability to finance Medicaid and reviews alternatives to the current federal/state financing arrangements, the most important consideration should be the impact of existing or alternative financing arrangements on the population who depend on the program. No population will be more affected by your work than women and children.

Women's and Children's Statue in Medicaid

Persistently high childhood poverty rates, an eroding private health insurance system and expansions enacted since 1984 have combined to make Medicaid an increasingly important source of third party financing for maternity and pediatric care.(1) Indeed, children are more dependent on Medicaid than any other age group. Even in the early 1980s, before the rise in childhood poverty and the growth in the program, children's dependence on Medicaid was disproportionately great. In 1981 Medicaid accounted for 55 percent of all direct federal health expenditures on children, compared to only 25 percent of direct

expenditures on the elderly (whose primary source of public insurance is, of course, Medicare.) As Medicaid has grown, and as funding for other public health programs have shrunk in real dollar terms, this lopsided dependence on Medicaid by children undoubtedly has intensified. Indeed, the entire system of federally funded health care programs for children, including local public health agencies and community and immigrant health centers, is significantly dependent on Medicaid for sizable operating revenues.

The magnitude of Medicaid's role as a financier of maternity and pediatric care is startling. Based on childhood poverty rates alone, we estimate that the program is now either the exclusive or a primary source of health coverage for more than 40 percent of the approximately 4 million births which occur annually. Many states (particularly those that have elected to cover all pregnant women and infants with family incomes below 185 percent of the federal poverty level) report that the program is now financing over half of all births. For children (particularly young children who have been the beneficiaries of many of the recent expansions) the program is positioned to become the chief payor for potentially one-third of all pediatric health care furnished in the United States.

As a health care financing program grows to this size, its potential to influence the quality and stability of an entire health system also grows. For example, in states in which Medicaid is financially responsible for half of all the obstetrical beds in a hospital system, the program's underfunding and structural or inadequacies are felt by all patients, not just those enrolled in Medicaid. Indeed, the high volume of

obstetrical care for which Medicaid ostensibly is responsible has caused many institutions to close, curtail, or relocate their obstetrical services, either because of an insufficient number of physicians willing to admit and deliver Medicaid-eligible women or because of very low reimbursement levels. Similary, in communities in which children's dependence on Medicaid is extremely high, the economic instability of both ambulatory and inpatient pediatric services generally may be threatened if the program performs poorly. Thus, as this Subcommittee considers the effect of Medicaid's inadequacies on women and children, it is essential to appreciate that the program's shortcomings potentially affect far more than just the women and children it serves directly.

There is nothing on the immediate horizon to suggest that women's and children's dependence on Medicaid will lessen. Poverty now claims 20 percent of all children, more than one third of children living in families headed by an individual under age 30, and half of all black and Latino children. The recession into which the nation appears to be heading undoubtely will push childhood poverty levels even higher and make children's dependence on Medicaid that much greater, given the high correlation between poverty and lack of health insurance. A recession undoubtely will also aggravate the already high proportion of women of childrearing age and children without private insurance. In 1987, even in the midst of a prolonged economic recovery, the proportion of children and women of childbearing age without private insurance was high and growing. That year, 9.5 million women of childbearing age, and between 9 and 12 million children, were completely uninsured. Between 1980

and 1987 the proportion of children without private insurance climbed by nearly 20 percent. By 1987 less than half of all black children in working families of all income levels were privately insured and only 62 percent of all children had employer coverage.

In the absence of comprehensive national health reform, we hope and expect that Congress will continue to expand and improve Medicaid coverage for women and children and strengthen the capacity of health care providers such as community health centers and community hospitals that furnish a high volume of quality health care to low income and medically underserved children. However, as these improvements are enacted, children's dependence on the program will once again increase.

Medicaid's Achievements for Children

Access to insurance cannot be equated with access to health care. But in an insurance based health care system third party financing is an absolute prerequisite to access. Medicaid's impact on women's and children's access to care has been enormous and this Subcommittee should be highly concerned about barriers to the program's adequate scope and effectiveness. The impact of Medicaid has repeatedly been measured.

Infant mortality reduction and access to maternity care: Enactment of Medicaid coincided with a twelve percent increase between 1969 and 1980 in use of early prenatal care among black women. Medicaid virtually eliminated medically inappropriate out-of-hospital births, particularly in the South and helped underwrite a host of new infant care technologies that have not only saved lives but prevented lifelong disabilities among infants born too soon, too small, and with grave health threats.

Each dollar spent to provide comprehensive maternity care through Medicaid has been shown to save two.

To the extent that Medicaid expansions have coincided with an erosion in use of early prenatal care, this phenomenon is an indication of the declining availability of health resources themselves rather than the inherent inadequacy of Medicaid. From 1965 to 1980, as the public health system grew along with Medicaid, access grew. During the 1980s, as funding for health clinics and community health centers declined, so did service utilization. The new Medicaid revenues will help those providers significantly, but it is too soon for Medicaid expansions yet to have had a measurable impact on the public health system.

Access to preventive and primary pediatric care: Medicaid's Early and Periodic Screening Diagnosis and Treatment (EPSDT) program, originally enacted in 1967, is the most comprehensive and important primary health program for children ever established by Congress. EPSDT has reached countless millions of children over the past two decades with health exams, vision, dental, and hearing services, immunizations, and services for children with physical, mental and developmental illnesses and disabilities. Children enrolled in EPSDT have been shown to have annual health care costs 10 percent lower than children who are not enrolled, and each dollar spent on childhood immunizations has been shown to save more than ten. Low income children with Medicaid coverage have been shown to be more likely than either their uninsured or privately insured counterparts to use preventive health care.

Care for children with disabilities: Medicaid has been

shown to be extremely effective in promoting access to care for children with disabilities. For example, low income children enrolled in special education programs who have Medicaid coverage have been shown to use greater levels of health care than either uninsured or privately insured low income children.

Medicaid, Children and the States

Children are a good investment for state Medicaid programs. On a per capita basis they are the least expensive beneficiaries (which should surprise no one, since fortunately most children are, neither sick nor disabled). And much of the care children need is highly cost effective.

But many states either cannot (or in a few cases, perhaps, choose not to) invest in children through Medicaid to the extent they should. In recent years, Congress has introduced a great deal of uniformity in eligibility and benefit requirements to the children's portion of Medicaid. All states must cover pregnant women and children with family incomes below 133 percent of the federal poverty level, and by the next century, all poor children under 19 will be covered. Amendments to the EPSDT program enacted in 1989 considerably expand and unify the amount, duration, and scope of benefits to which children are entitled. Federal reforms affecting both private obstetric and pediatric providers and community health centers serving large numbers of women and children promise to upgrade access to maternity and pediatric care.

But much needs to be done. The 1990 amendments extending Medicaid coverage to all poor children under 19 will be phased in painfully slow. Children over age 7, who are "too old" to be affected by the new phased in expansions, will be relegated

to existing eligibility criteria. These criteria are terrible. Twenty states still do not cover all children ages 8 and older whose families are poor enough to qualify for AFDC but who do not meet the AFDC "dependency" test, because neither parent is absent, incapacitated or unemployed. And the financial eligibility criteria applied to all children too "old" to qualify for benefits under the 1990 phased in, expansions are as low as 13.4 percent of the Federal poverty level.

Less than half of all states have elected to cover all pregnant women and infants with family incomes below 185% of the Federal poverty level -- the minimum level in our opinion that should be used to determine eligibility for all children and pregnant women. Some states continue to use cumbersome asset and documentation requirements, nearly all states effectively exclude otherwise eligible migratory workers because of the state residency requirements that come with a state-financed program.

With respect to benefits, there continues to exist wide variation in benefit levels, and even more so, in the criteria used to determine when a covered benefit is reimbursable as medically necessary. For example, children in Massachusetts who have mental illness can obtain a substantial amount of outpatient care. In Alabama they qualify for virtually no outpatients care at all. Similarly, many states continue to use outdated, obsolete standards to determine coverage of such basic services as childhood vaccines, as the attached letter shows.

Whether or not states can afford to do more, we think the time has come to federalize Medicaid reimbursement at least for the non-long-term care portion of the program, beginning with obstetrical and pediatric services. Fifty seven separate

Medicaid programs no longer make sense for any population in need, but this is particularly true for pregnant women and children whose eligibility coverage entitlement have been increasingly unified in recent years.

Finally, if Medicaid payments are federalized, it is essential simultaneously to preserve the current scope of benefits to which children are now entitled, to unify benefits for pregnant women, to simplify program eligibility criteria (including eliminating the use of asset and state residency tests) and to develop enrollment mechanisms at all locations in which children are served, such as clinics, schools, child care and Head Start programs and other locations.

JAMES P. BEITTEL, M.D. HILARY BECKER, M.D.
800 ESTELLE DRIVE
PEDIATRICS LANCASTER, PA. 17601 717-898-2407

8 November 1990

The Honorable John F. White, Jr.
Secretary of the Commonwealth
Department of Public Welfare
PW333, Health and Welfare Building
Harrisburg, PA 17108

Dear Secretary White:

Current recommendations require administration of HEMOPHILUS INFLUENZA TYPE B CONJUGATE VACCINE to children in four (4) doses at 2, 4, 6, and 15 months of age. Department of Health is providing this vaccine for one (1) dose only at 18 months of age through clinics operated by its county level offices and other non-profit clinics. Dispensing physicians may administer the vaccine and invoice DPW, but this avenue is denied to State Health Clinics and other non-profit clinics which are prohibited by DPW regulation from achieving dispensing status.

This causes a dilemma for non-profit clinics such as Southeast Lancaster Health Services with which I am associated as a provider of primary pediatric (both illness and well) care in that area of Lancaster City.

1. State Health will not provide HIB vaccine except for administration of a single dose to children between 18 and 60 months of age. No funds is the reason given.

2. The clinic is unable to obtain dispensing status in order to be reimbursed for the cost of the vaccine.

3. Last year the clinic completed over 700 EPSDT examinations and provided timely immunizations to those in need thereof, as required under EPSDT regulations.

4. The clinic (just like the state) has no discretionary funds available with which to purchase the vaccine.

5. Hemophilus influenza type B invasive disease (meningitis especially) is a common, permanently disabling, and now preventable disease in children between 2 and 18 months of age. The liability to the clinic and its practitioners if we do NOT administer the vaccine as recommended is unacceptable both legally and medically.

The bottom line is that the clinic may have to discontinue administration of vaccines altogether, as well as participation in the EPSDT program, because we are fiscally precluded from fulfilling our obligation to our patients, and unable and unwilling to assume the liability for our failure to provide complete care as recommended.

This is indeed a Catch-22 which is here and now. How do you recommend the clinic deal with it?

The same problem presents in regards to reimmunization with measles vaccine, but the magnitude is vastly different; most studies suggest that more than 95% of adolescents have protective levels of immunity to measles from the single dose of vaccine received in the second year of life; thus a booster is redundant at least 19 times out of 20. Absenting an epidemic, this problem is more theoretical than real.

Sincerely yours,

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Mr. WEISS. There are approximately 26 million Medicaid beneficiaries who are eligible for a wide range of services through State programs, but for every Medicaid patient, there is at least one American who lacks health care coverage of any kind.

Who needs health care that is not covered under Medicaid?

Ms. ROSENBAUM. There are millions of people who are left out, including millions who at this point are perceived as having been covered by recent reforms.

As I noted, children who are over the age or income cutoff for the expanded programs are left out in many States, if they are desperately poor but over age 8, if they are very young, and if they are members of working poor families.

Right now, a black child living in a working family has a less than one in two chance of having access to private health insurance in the United States.

So the numbers of poor and near poor children and working adults, and as was mentioned, single adults, childless couples, who are left out of the program is enormous.

Mr. WEISS. Ms. Boardman, if you feel that you want to supplement, please respond.

Ms. ROSENBAUM. I am having a hard time hearing you, Mr. Chairman.

Mr. WEISS. If you feel that you want to supplement any of the responses, please feel free to do so.

Ms. ROSENBAUM. Thank you.

Mr. WEISS. Ms. Rosenbaum, would it be fair to say that even given recent congressional mandates to expand the program, Medicaid fails to meet the health care needs of many poor Americans?

Ms. ROSENBAUM. Absolutely.

The mandates have been exceedingly important. I think it should be stressed that despite all of the problems that Medicaid beneficiaries do encounter in finding care, if you had a panel of four poor families here, and you asked them how they valued their Medicaid card, they would place high value on their Medicaid card.

That is a fact that shouldn't be lost sight of, because ultimately what will justify further reforms by Congress is the notion that Medicaid is an inherently valuable benefit.

It may not be as good as a unified national health plan, but the difference it makes in lives of families is enormous.

Therefore, you should continue the expansions.

Mr. WEISS. You cited the Pennsylvania example and you said that they have discontinued providing vaccines because the State Medicaid program will not pay for them.

What is your sense of how often physicians have to curb services to patients because of State restrictions?

Ms. ROSENBAUM. Our experience is that it is rampant for a number of reasons.

There are cases, as indicated by the testimony submitted by the National Governors Association, in which a State makes a deliberate decision to cut out an entire class of patients because it can't afford the services, as Arkansas' recent decision to cut out its medically needy adult program exemplifies.

A program such as the early and periodic screening and diagnosis and treatment program, which is the major pediatrics program

in Medicaid, needs to be upgraded and strengthened to bring it into conformity with evolving standards of medical practice. There is no better example of this than vaccines.

Another compelling example is pediatric dentistry. Another is services for children with mental illness and developmental delays. In all of these situations States simply out of a lack of funds do not bring programs into conformity with evolving standards of medical care. This is as equally serious as cutting back on a preexisting program. Medicaid now funds many services that potentially could be construed as social or educational services, but which we have chosen for a number of policy reasons, some good and some not so good, to conceive of as medical assistance.

Therefore, the program has to live up to a very broad mandate.

Mr. WEISS. Are you able to quantify the numbers of children who are in need of health care and who are not being served by Medicaid?

Ms. ROSENBAUM. At this point, both we and the White House Task Force on Infant Mortality, in its 1989 report estimate that about one in every two births in the United States right now is low income, below 200 percent of the Federal poverty level.

If you look at insurance distribution figures, without question, children or adults living at 200 percent of the Federal poverty level and below, are in need of some sort of supplemental, if not complete, public health insurance coverage.

Of all the children in the United States, only about 12 million right now are eligible for Medicaid, and we are probably close to 30 million children under age 18 who have income within striking distance of 200 percent of the Federal poverty level.

All of those children should have access to Medicaid, either automatically or else their families should be able to secure it if they don't otherwise have private coverage.

So the gap is twice the number of children now served under the program. I should add that there are a lot of children eligible for Medicaid under current standards who because of the kinds of problems that were alluded to are not enrolled and, therefore, there are probably another several million children who should be enrolled in Medicaid right now and are not.

Without more aggressive case finding, those children wouldn't be enrolled. But States have an inherent unwillingness to engage in aggressive case finding if, in fact, every case found is going to cost a lot of money.

Mr. WEISS. Where do uninsured children go for help?

Ms. ROSENBAUM. If they are fortunate, they live near a community or migrant health center, funded mainly by the Federal Government, which provides care to over 3 million children in the United States, about half of whom right now have Medicaid.

In some places children are fortunate enough to live close to a city or county health department system that offers comprehensive ambulatory care.

Children who are not so fortunate go to hospital emergency rooms. Pregnant women who are not so fortunate go to hospital emergency rooms and the extent of the problem is striking.

If you go to a hospital emergency room, one of the most riveting aspects of being there is that families will sit and wait hours and

hours and hours. They, obviously, wouldn't be sitting and waiting hours and hours if they had somewhere else to go.

In Los Angeles several weeks ago, clinics were reporting turning away as many as 12 to 15 sick children a day because they were so overwhelmed with patients who had nowhere to go that they couldn't see them all.

Mr. WEISS. If every State provided all the optional services available under Medicaid, how many more people in need could be reached?

Ms. ROSENBAUM. Few States have expanded their programs to the maximum amount allowed under Federal law. In the case of pregnant women and infants, Federal law allows States to cover any woman and infants with families' income of below 185 percent of the Federal poverty level, which is the same income cutoff used for the WIC program now.

Fewer than half the States do that. One State is threatening to roll back its coverage now as a Medicaid cutback option. If all States picked up the 185 percent option, another 100,000 births a year would be picked up.

As far as children go, we really don't have too many options left. Congress has managed to mandate a lot of poverty coverage requirements. The problem is that the phase-in is very slow, so States don't have the option right now of immediately covering all poor children.

That is an important next step to take in the program. There are many adults who could be covered under Medicaid. The medically needy adult population includes older people and young working adults. For example, a working mother in Alabama who may be earning the minimum wage who at least could get access to some emergency care if the State had a medically needy program and if she could enroll by spending down. A spend-down program is difficult to use but it is important in the event that care is needed.

We see the greatest failure in the area of access to preventive care. For example, a woman who is not pregnant has no access, unless she happens to get public assistance, to preventative reproductive, preventative health service such as pap smears for cervical cancer and mammograms for breast cancer and other kinds of reproductive health services.

Mr. WEISS. What is your sense as to why States aren't providing all the services that are included in the Medicaid program now?

Ms. ROSENBAUM. In most cases, I think most States without question don't provide the services because they don't feel they can afford the program. There are some States—it is true as GAO has noted—that there are some States that underspend if you look at their capacity to raise revenues and invest in health care. But the great majority of States, I think, believe that they are doing about what they can do in light of the difficulties they face in justifying major expenditures under Medicaid to State legislatures.

I think that while there may be some valuable adjustments that can be made in the formula, I think the country is at a crossroads of having to decide whether the adequacy of the program ought to depend on States' perceived financing capabilities.

Mr. WEISS. What is your view of the formula discrepancies?

Ms. ROSENBAUM. I think that there are several better measures than per capita income. That kind of message does not take into account wide variations in the size and intensity of the medically indigent population.

I am not sure that the poverty population in and of itself is a particularly good measure of a health insurance program. Medical indigence is a complex issue; I think another major problem is the cost of medical care. It simply costs a lot more for a Medicaid program to buy adequate medical care in some States—New York, Massachusetts—than in other States. That is a problem.

Certainly, I think the real issue is whether the level of Federal contributions is enough, given the numbers of people who have fallen into Medicaid because of other lapses in Federal policy. The fact is that the Federal Government has not come to grips with the large numbers of uninsured Americans. This can only be done at the Federal level because of tax laws and other laws affecting the provision of insurance. So many people now depend on Medicaid, the question is whether the Federal Government should step in with a higher level of contribution for all States, not just the ones with more dense poverty populations.

Ms. BOARDMAN. I would like to add that from experience in our State, it can be an attitude question somewhat, too. We were certain, those of us who are advocates, that our nursing homes were not being reimbursed nearly up to the costs of care of the patients and training for the staff was inadequate. Ninety-five percent of the direct care was being provided by nonprofessional staff, and there was 100 percent turnover in staff each year. And one of the arguments given frequently was that some of the providers were for-profit enterprises and were trying to "clean up."

Well, this affected the reimbursement for some very good small for-profit providers, too. And it took an act of the legislature finally to make the change, the base year on which reimbursements were computed, and to raise the reimbursements, and we are not there yet.

Mr. WEISS. Would you comment, either or both of you, on any experience you have had by way of observation or studies regarding the storefront clinic, the so-called Medicaid mills? We have held some hearings on that subject, and it is an instance in which my general feeling is that many times—perhaps more times than not, the people—the individuals who go there would be better off not getting any kind of medical care than getting that kind of care.

What is your experience?

Ms. ROSENBAUM. I think the legislation you introduced and was passed last year was extremely important. I think one of the most important aspects of the legislation is that it is going to show Congress and the administration just how underserved some areas of the country are, because they have been subsisting on seriously substandard care.

We have great concern about the storefront clinics that simply funnel a lot of patients through who come in off the street. We are equally concerned about the quality of care provided at a lot of the sites used by States in administering Medicaid prepaid health plans, these plans are not simply taking haphazard patients as they come in off the streets, but have families actually enrolled.

Some of these providers furnish poor quality or nonexistent services.

Given the fact most States are targeting their AFDC populations for enrollments, two-thirds are children, and all the remainder are women of child-bearing age. If the plans are poor quality, it is most heavily felt in the area of maternal and child health services.

Too frequently prepaid plans do an extremely poor job in the most basic areas, not to mention on the high-cost side. Services as basic as vaccines, childhood immunizations, well-child exams, prenatal care, and then, of course, services to manage children who, disproportionately in this population, have chronic illnesses and disabilities are seriously lacking and of seriously poor quality.

I think that if Congress wants to do something—in addition to investigating plans and setting standards for the operations of the plans, the time has come to think about a vast expansion of those programs that underwrite good quality clinics in underserved areas, and that expands programs such as the National Health Service Corps to meet the needs in these underserved areas.

Mr. Weiss. I thank you both very, very much for your testimony and for the tremendous work your organizations do throughout the year, day after day. And hopefully, the positions you have advocated for will ultimately see the light of day. Thank you very much.

I know Governor Clinton has arrived. Governor, welcome, and we are prepared for your testimony on this very important subject. We have a prepared statement from you. You are welcome to deliver that, or use it as a takeoff, any way you prefer it. It will be entered into the record in its entirety.

## STATEMENT OF BILL CLINTON, GOVERNOR, STATE OF ARKANSAS, ON BEHALF OF THE NATIONAL GOVERNORS' ASSOCIATION

Mr. Clinton. Thank you very much.

I think you and I both have the same problem this morning. I have been out looking for my voice, and haven't found it. Nonetheless, I will do my best to get through the summary of my testimony.

Let me begin by thanking you for looking into this terribly important question of the adequacy of the Medicaid program and the financing problems and how—I think the Governors' position on Medicaid has to be viewed within the context of two very important environmental issues, if you will.

First, history of the Medicaid program itself. And, second, the crisis in our health care system and the Governors' role in that.

To begin with the latter point, as you well know, the increased spending on health care, which is due to climb about 15 percent of GNP by the end of the decade, unless something is done. In spite of the fact we have a huge share of uninsured people, has left the Governors—of all State and publicly fundable health programs many, many difficult positions.

We know Medicaid or an insurance card, moreover, does not insure care. Therefore, in addition to covering and financing programs, we have to look at the adequate funding of our public health facilities; transportation needs of poor and rural people; out-

reach efforts in providing adequate delivery systems for health care where they don't exist.

Employers, as you well know, are also experiencing double-digit increase in costs, as well as State government. Small employers are increasingly priced out of the market, further aggravating the problem of the uninsured population.

Every year, when we sit down to do our budget, we have to play takeaway. I will come back to this in a moment.

Because we operate on a balanced budget, we figure out how much new money we are going to have, and then we take away. We take away what it costs to run the penitentiary, what it costs to pay health insurance bills, and what it costs to meet any new mandates imposed on us by Congress.

Then we figure out what we can do for education, environment, economic development and other things. That takeaway game, and its attendant frustrations, I am convinced led to the 1989 resolution the Governors' Conference adopted with the signatures of 48 of the 50 Governors, asking for a 2-year moratorium on new Medicaid mandates.

The program was originally designed to provide care to a small subset of the poor population: AFDC mothers and their children, and recipients of Federal SSI. Over the years, special populations and services have been added, the most important of which is skilled nursing care, which now consumes about two-thirds of the resources of Medicaid, while serving about one-third of the Medicaid population.

President Reagan tried to cap Medicaid in the early 1980's and failed through the efforts of Congress and the Governors, but even with the increased flexibility granted to the States for a compromise for slowing the rate of growth, recession in the early 1980's made it impossible to fund Medicaid and increase AFDC payment rates, with the consequence that real AFDC rates are much lower today than they were 10 or 15 years ago.

In 1985, the southern Governors, alarmed by the increased rates of infant mortality, proposed delinking AFDC and Medicaid eligibility to provide States with low AFDC eligibility the opportunity to provide Medicaid coverage to pregnant women and children.

In 1986, the National Governors' Association adopted that recommendation. And in 1986, Congress did provide States the option to provide pregnant women and infants to age 1 through Medicaid in cases at or below 100 percent of the Federal poverty line. Today, 44 States do that.

In 1987, Congress expanded the option to allow States to cover pregnant women and infants up to 185 percent of poverty. Nineteen States do, and several others would have done that, even without the mandates in 1991.

In 1988, it was Medicare catastrophic, which mandated coverage of pregnant women and infants up to 100 percent of poverty, and required States of pay Medicare cost-sharing requirements for all eligible adults below the Federal poverty level.

I think this is very important. When Congress repealed the Medicare catastrophic bill, it did not repeal provisions which mandated new Medicaid spending on the States. It was at this juncture the

Governors expressed their frustration in the Chicago. First, call attention to the costs of Medicaid.

Yet, in 1989, Congress mandated coverage for pregnant women and children up to age 6 with an income at or below 133 percent of poverty. This year, the new mandates cover children through age 18 with incomes below 100 percent of poverty.

No Governor would argue the merits of the policy to protect pregnant women and children. I was a southern Governor who voted for the 1985 resolution. My wife was on our Infant Mortality Task Force. We wanted the opportunity in the poor Southern States to cover more pregnant women and children.

Nobody would argue the merits of improving nursing home care, extending Medicaid to welfare recipients, leaving their roles for work—that was part of our welfare reform bill—or even helping more of the poor elderly.

But if you look at the combined effect of these mandates, it has stretched the States beyond their fiscal and administrative capacity. Let's look a little bit at the impact, first of all, on the States' budgets and on the States' Medicaid decisionmaking.

The National Association of State Budget Officers' study of fiscal conditions of the States reveals that the overall fiscal condition of the States is as bad or worse than it was in the early 1980's in the depth of that recession.

In 1990, 20 States and the District of Columbia reduced inactive budgets. Other States borrowed from internal funds to balance their budgets. Much of this pain is directly related to Medicaid. Even without this year's mandates, State and Federal spending for Medicaid would have risen $75 billion over the 1990 baseline for the next 5 years.

The 1987 mandates will cost the States $4.6 billion in fiscal years 1991 and 1992. The 1990 expansions of OBRA will cost an estimated $3 billion over the next 5 years.

Medicaid is now the fastest growing State spending program, even faster growing than the prison. Expenditures increased 18.4 percent in 1990, and now consume approximately 14 percent of the average State budget.

In my State, from 1987 through the present, Medicaid mandates have increased annual State obligation by $25 million, or 1.3 percent of annual State spending. Since we must balance our budget, with the new mandates in 1990—last year, we had to cut approximately $30 million out of our Medicaid program. That is $30 million State and Federal.

So, we absorbed more than half of the Medicaid mandates through administrative changes, but we did have to cut $30 million out of the Medicaid program, our adult medically needy program. All adult recipients are now without dental and therapy services. We lowered benefit limits on hospital days and home health benefits.

In other words, it is very important to hammer home here. Medicaid used to be a program with a lot of options and a few mandates. As it becomes a program with more mandates, it is becoming inevident for budgetary reasons, a program with fewer options.

So, as Congress enacts the mandates, a decision is being made by Congress to reduce options and cut out services previously being delivered.

The States that find it difficult to raise taxes to fund Medicaid programs, had it been asked for a decade to pay for their own education, environmental and infrastructure expenses. The fact just 10 days before the last election, every Governor in the country and everybody running for Governor had the rules changed in the minds of the voter, on who raised taxes and who didn't, makes it even more difficult in the future to raise new revenues to fund Medicaid.

If that is the case, every new mandate may lead to a corresponding reduced Medicaid option coverage. That may be a decision Congress wants to make, but it cannot be laid solely at the feet of the States, because of the balanced budget requirements and the difficulty in any season of raising taxes which have been increased by the events of the last few weeks.

Despite these cuts in coverage and services, our State, just to meet Medicaid mandates, with the large number of people who are now being served, is probably going to have to pump an additional $16 million, or almost 1 percent of State spending into Medicaid between January and July of 1991, just to fund current services.

If we were to add back the medically needed program, it would cost another $5 million. Now, we are doing all this without even thinking about how we are going to absorb this year's mandates.

In Arkansas, I am afraid we will soon have a Medicaid program that only covers the mandates at the expense of other optional services that are very important to a lot of our people.

That is why the Governors passed the resolution they did, not because there is anything wrong intrinsically with any of the mandates.

Indeed, many of us have urged our people to cover more of these services, but the decade of Federal mandates has placed a significant burden on our States. We have no choice that involves deficit spending or even being flexible in revenue growth.

In the end, we have to either raise taxes or cut other viable services in times when revenue growth is meager in virtually every State in the country. It is very meager today.

I applaud your interest in this. I would say that the Governors' Association has organized the Health Care Committee, of which I am the vice chairman, to attempt to resolve these and other health issues in a much more comprehensive fashion.

The Governors stand ready to do their part. I think our people are ready to do their part, but the piecemeal, slow addition of mandates is having, I would suggest, unintended and perhaps even unforeseen consequences, the most important of which is we are reducing optional coverage under Medicaid which Congress may hope the States would adopt, No. 1.

And, No. 2, in an environment where revenue growth is limited and tax increases are difficult, we are taking funds away from those investments in the future which would give us healthier economies, more tax sets, and more money to spent on health care.

Because if you can't get the money out of revenue growth or new taxes, then the money you spend to fund Medicaid mandates is

money that would have gone to educate children and strengthen our long economic position.

In a State in which education is grossly underfunded, it is at best unclear whether we are better off spending money on Medicaid or education for the long-term interest of our children. It is a choice we would like not to make, but a choice which these mandates have increasingly made necessary.

Thank you very much.

[The prepared statement of Mr. Clinton follows:]

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STATEMENT OF

THE HONORABLE BILL CLINTON

GOVERNOR OF ARKANSAS

REPRESENTING THE

NATIONAL GOVERNORS' ASSOCIATION

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS

COMMITTEE ON GOVERNMENT OPERATIONS

U.S. HOUSE OF REPRESENTATIVES

HEARING ON MEDICAID MANDATES

DECEMBER 7, 1990

Good morning, Mr. Chairman and members of the Subcommittee. It's a pleasure to be here this morning on behalf of the nation's Governors to talk with you about states' ability to finance the Medicaid program.

In order to clearly understand the Governors' position on Medicaid, it is important to understand the context within which most Governors think about and deal with the program. First, it is just one piece of a much larger health care crisis and that crisis hits Governors in a number of ways. Second, there is a history of gubernatorial concern with and involvement in Medicaid policy.

Health care in the United States is nearing a state of crisis. In 1983, the U.S. spent $357 million, or 10.5 percent of our gross national product (GNP), on health care. By 1989, those figures had climbed to more than $599 billion, or 11.5 percent of our GNP--that's $2,400 for every man, woman, and child in the country. Left unchecked, health care costs are projected to rise to $1.5 trillion, or 15 percent of our GNP, by the year 2000.

Yet millions of Americans have limited or no access to the health care services they need. If you examine only the insurance statistics, the figures are appalling. Approximately 31 million people are uninsured annually, and 37 million are uninsured in any given month. Governors, who are responsible for the health and welfare of their citizens, understand clearly that health insurance or Medicaid coverage does not ensure access to services, particularly for our poor and rural citizens.

Because there are so many other factors that make a difference in whether people actually have access to health care services, Governors must also attend to the following kinds of issues: adequate funding of their public health effort; the transportation needs of poor and rural citizens; the outreach efforts that result in people using health care services more effectively; and the careful screening and licensing of health care personnel and facilities.

Employers, the traditional source of insurance coverage for our workers and their families, are experiencing double-digit increases in their employee health insurance premiums. Their responses have ranged from dropping coverage for their workers' dependents to decreasing coverage for their employees. For most small businesses, increasingly expensive health insurance is simply beyond their financial reach.

Governors, too, are employers. In fact, in some states, government is the largest single employer. And as employers, Governors suffer the same premium increases and face the same draconian choices as any other employer in the state.

Governors have a long history of involvement in Medicaid policy. As most of the members of the Subcommittee know, in 1989 the Governors

overwhelmingly endorsed a resolution calling on Congress and the White House to halt the enactment of Medicaid mandates for a period of two years. The Governors proposed to use the two years to work with Congress and the White House on a bipartisan basis, as we did on welfare reform, to find the best way to respond to escalating health care costs while ensuring access to needed health care services for all Americans.

Why this extraordinary move by the Governors? Some history of the Medicaid program helps provide context for this action. When Medicaid was enacted into law in 1965, it was designed to be a program that provided health care services to Aid to Families with Dependent Children (AFDC) - eligible women and children and to the aged, blind, and disabled covered by federal Supplemental Security Income (SSI). States were accorded the responsibility to set eligibility levels for AFDC, while the federal government sets eligibility for SSI.

Within a decade of its establishment, however, the Medicaid program had become the place to serve all kinds of special populations who had no access to health care through any other means. Thus, in the late sixties and early seventies, important but expensive special populations and services were added to the program. A prime example of this trend is the addition of skilled nursing home care as a required service under Medicaid in the early seventies. Today about a quarter of all Medicaid recipients receive long-term care services, yet those services consume about two-thirds of the Medicaid budget.

As the Medicaid program grew, Governors increasingly found it difficult to both provide coverage for new populations and services and increase their AFDC eligibility standards, which might have brought more of the original population into the program. In the late seventies, a National Governors' Association (NGA) task force on federalism proposed that the states take full responsibility for the AFDC program in exchange for the federal government taking full responsibility for Medicaid. The proposed swap eventually broke down over the issue of who would take long-term care, which had already become a major source of growth in Medicaid.

In the early eighties, President Reagan proposed a cap on Medicaid to curb escalating costs to the federal government. The Governors and Congress aggressively fought this proposal; the ultimate compromise was a cap on program expenditure growth for two years. The quid pro quo for states was an expansion of states' authority to use federal waivers to forge creative solutions to Medicaid problems. But the continued growth in Medicaid program expenditures, combined with an economic recession, made it increasingly difficult for states to expand their AFDC eligibility and include more poor women and children in the program.

In 1985, the Southern Governors' Association responded to alarming rates of infant mortality in the South by forming a southern regional task force on infant mortality. That task force recommended that eligibility for Medicaid be separated from eligibility for AFDC for pregnant women and children. In this way,

states with historically low AFDC eligibility thresholds could provide health care coverage to poor women and children even though they were not eligible for AFDC.

Early in 1986, NGA adopted this recommendation in the form of a policy that called on Congress to give states the option to provide Medicaid coverage to pregnant women, infants, and children up to the age of eighteen who were at or below the federal poverty level.

In the Omnibus Reconciliation Act of 1986, Congress responded to the Governors by providing the option for states to extend Medicaid coverage to pregnant women and infants up to the age of one year whose incomes were at or below 100 percent of poverty and permitted the states to phase in coverage to children up to the age of five over a three-year period. Forty-four states adopted this option.

In the Omnibus Reconciliation Act of 1987, Congress expanded the options and permitted states to cover pregnant women and infants up to 185 percent of poverty and immediately cover children up to the age of five to 100 percent of poverty. Nineteen states took the option within a year.

However, the 1987 legislation began what has now become a trend to replace state options with federal mandates. The 1987 law, for instance, included provisions intended to improve the care provided in nursing homes.

In 1988, Medicare catastrophic legislation mandated that states pay the costs to cover Medicare cost-sharing requirements for all eligible adults below the poverty level and mandated state coverage of pregnant women and infants to 100 percent of poverty. It is important to note that when Congress repealed the catastrophic legislation the next year, it did not repeal those provisions that mandated increased state responsibility. It was at this juncture that the Governors passed their "no-more-mandates" resolution.

Yet, in 1989, Congress mandated coverage for pregnant women and children up to age six whose incomes were at or below 133 percent of poverty. In 1990, the mandates extended coverage to children through the age of eighteen at or below 100 percent of poverty.

While there is no Governor who would argue that providing health care coverage to women and children, improving nursing home care, and extending Medicaid to welfare recipients leaving AFDC for work are not decent policy ideas, the combination of these rapidly expanding Medicaid mandates has stretched states beyond their fiscal and administrative limits.

And despite our efforts over the last two years to communicate the extent of our fiscal pain and administrative concerns to Congress, Medicaid expansions remain the focus of the federal effort to increase access to health care. It appears to us that what is really happening is a "back-door approach" to universal health care, using Medicaid as the vehicle and the states' credit cards as the financing mechanism.

Let's look at some fiscal facts. First, as the material attached to my testimony from the National State Budget Officers' Association's recent Fiscal Survey of the States indicates, state fiscal conditions were weak in 1990 and will grow worse in 1991. In Fiscal 1990, twenty states and the District of Columbia reduced their enacted budgets. Additionally, several other states borrowed from internal funds or delayed payments to balance their Fiscal 1990 budgets. If states had not taken action to address the imbalances that developed, more than half the states would have ended Fiscal 1990 with a deficit.

Further, much of the fiscal pain states are feeling is directly related to increased Medicaid spending. If Congress had decided to halt this year's Medicaid mandates, the Medicaid program would have cost the federal and state governments $75 billion over the 1990 base budget the next five years. Federal Medicaid expansions enacted since 1987 will cost states more than $4.6 billion in Fiscal 1991 and 1992. In addition, OBRA 90 expansions will cost states an estimated $3 billion during Fiscal 1991 through 1995.

Medicaid is growing faster than any other state spending program. State Medicaid expenditures increased 18.4 percent in Fiscal 1990 and continue to consume a growing portion of state expenditures. Right now, Medicaid alone consumes about 14 percent of a state budget and is expected to consume 17 percent by 1995.

Let me tell you what that means in Arkansas. From 1987 through the present time, Medicaid mandates have increased our annual state dollar obligation by $25 million. This is in the context of a state general revenue budget of $1,862,000, or 1.3 percent of our annual state general revenue dollars. In the face of this burden, we were required by state law to take action to balance our budget. Last August we were forced to implement some $30 million total state and federal funds in cuts to our Medicaid program--primarily because of known federal mandates.

Most significant among the cuts we implemented was the elimination of our adult medically needy program. Further, all adult Medicaid recipients are now without such services as dental and therapy services. We also were forced to lower benefit limits on hospital days and home health visits. Yet despite these cuts in coverage and services, the state must pump an additional $16 million into Medicaid between January 1991 and July 1991 just to fund current services. If we were to restore our medically needy program, it would cost us an additional $5 million.

And even as we face an additional $16 million infusion of state funds to fund current services, we are also trying to absorb and account for the fiscal impact of the newest Medicaid mandates.

In Arkansas we will be confronted with the possibility of further reductions of the ever-narrowing optional Medicaid services. In short, I feel we may be nearing a Medicaid program that covers only federally mandated services at the expense of other health services that we deem important to our citizens.

Is this a federal-state partnership?

Mr. Chairman, in the discussion among Governors that led to the passage of our resolution in 1989, many questions were raised. Is Medicaid, with its institutional bias and inevitable link to the welfare system, the best way to provide preventive and primary health care to our women and children? At what percentage of poverty does providing Medicaid coverage through a publicly funded program usurp the long-standing relationship between employer and employee for private health insurance benefits? What do the numerous Medicaid mandates do to address the needs of the 37 million uninsured Americans, many of whom are working poor?

Underlying our concerns about Medicaid are the larger issues I addressed earlier. Escalating costs are fueled by many factors including general inflation, accelerated inflation in medical care prices, the aging of the population, patient demand, the practice of defensive medicine, and advances in medical science that lead to expensive new technologies. While costs escalate, however, we have too little information about the quality and outcomes of medical services.

Here is the real irony of the situation Governors now confront. The era of federal turnbacks and mandates has increasingly made state government the pressure point where the demand for government services rests. As the full impact of these federal mandates hits the states, we are simultaneously experiencing a recession that is increasing the AFDC rolls, increasing the rate of unemployment and creating an urgent demand for state services.

Governors are faced with two very unpopular and untenable choices. We can raise taxes or we can cut other critical state services, often to the very populations the mandates are designed to protect. As a recent editorial in The Washington Post suggested, "The squeeze is on, and the states are not just its victims but among its chief transmitters."

The health care crisis must be resolved. The National Governors' Association, under the leadership of Governor Booth Gardner of Washington, is undertaking a major reform effort this year. I am proud to be a vice chair of the NGA Task Force on Health Care, which will suggest ways in which states can respond to out-of-control costs and inadequate access to care and will offer suggestions for federal action to Congress and the Administration.

We do not underestimate the difficulty of such an agenda. But to continue to ignore the problem will consign millions of our citizens to needless suffering and allow spiraling costs to destroy our ability to attend to other critical priorities.

Thank you.

Mr. WEISS. Governor, thank you very much. Especially given your throat, I very much appreciate you taking the time to share your experience and wisdom with us. You have painted a very stark picture, indeed, which is replicated around the country.

I have some questions, and to the extent your voice holds out—if at any point you feel you have really had it, let me know and we will submit some of this stuff in writing.

The National Association of State Budget Officers recently completed a fiscal survey of State governments. Are you familiar with their study?

Mr. CLINTON. Yes.

Mr. WEISS. Would you like to comment on that, what their finding was?

Mr. CLINTON. We have a representative from the national association here who could answer any specific questions, but I think it is an accurate survey, and we would very much like it included in the record. It paints the picture that I have tried to describe.

Mr. WEISS. Without objection, we will, in fact, put that in.

[The information follows:]

ATTACHMENT

Intergovernmental Relations Subcommittee
Appendix to testimony of Governor Clinton on December 7, 1990
Prepared by the National Association of State Budget Officers

I. Fiscal Outlook

The results of our fiscal survey of the states published in September 1990 indicate that state fiscal conditions were weak in Fiscal 1990 and will grow worse in Fiscal 1991. In Fiscal 1990, twenty states and the District of Columbia reduced their enacted budgets. Additionally, several other states borrowed from internal funds or delayed payments to balance their Fiscal 1990 budgets. If states had not taken action to address the imbalances that developed, more than half the states would have ended Fiscal 1990 with a deficit. The imbalances were due primarily to poor revenue performance, particularly in the area of corporate tax receipts. Twenty-seven states collected less revenue than anticipated in Fiscal 1990. As a result, many states used accumulated balances to finance their spending. The attached Table A-4 illustrates the decrease in state balances from Fiscal 1989 to Fiscal 1991. Overall, balances declined from 4.8% in Fiscal 89 to 2.5% in Fiscal 1991. This is the lowest level of balances since Fiscal 1983, a recession year. The outlook for Fiscal 1991 is unimproved as revenues are below estimates in at least thirty states. Twenty-six states enacted tax increases for Fiscal 1991 totalling $10.3 billion. This is the largest single-year increase ever recorded.

II. Medicaid Growth

Federal expansion of the Medicaid program is a contributing factor to state budget distress. Federal Medicaid expansions enacted since 1987 will cost states more than $4.6 billion in Fiscal 1991 and 1992. In addition, OBRA 90 expansions will cost states an estimated $3.0 billion during Fiscal 1991 through Fiscal 1995. Medicaid is growing faster than any other state spending program. State Medicaid expenditures increased 18.4% in Fiscal 1990 and continue to consume a growing portion of state expenditures. To continue current Medicaid services over the next five years without any further expansions or options, the state and federal government will spend at least an additional $75 billion. As the states' economic conditions decline, AFDC, Food Stamps and Medicaid caseloads will continue to grow and place even greater spending pressure on state budgets.

Surveys and Graphs Attached:
1. Total Balances as a Percent of Expenditures, Fiscal 1989 to Fiscal 1991, Table A-4
2. Cost Estimates of Enacted Medicaid Expansions 1991
3. Cost Estimates of Enacted Medicaid Expansions 1992
4. Medicaid Spending 1970 - 1995
5. Medicaid Spending as a Percent of State Budgets 1970 - 1995

Table A-4

TOTAL BALANCES AS A PERCENT OF EXPENDITURES,
FISCAL 1989 TO FISCAL 1991

| Region/State | Total Balances ($ in millions) | | | As a Percent of Expenditures | | |
|---|---|---|---|---|---|---|
| | Fiscal 1989 | Fiscal 1990 | Fiscal 1991 | Fiscal 1989 | Fiscal 1990 | Fiscal 1991 |
| NEW ENGLAND | | | | | | |
| Connecticut | $102 | -$157 | -$379 | 1.8 % | -2.5 % | -5.8 % |
| Maine | 188 | 65 | 7 | 12.7 | 4.3 | 0.4 |
| Massachusetts | -442 | -1,226 | 41 | -3.5 | -9.1 | 0.3 |
| New Hampshire | 35 | -30 | -5 | 6.1 | -4.9 | -0.8 |
| Rhode Island | 51 | 3 | 6 | 3.6 | 0.2 | 0.4 |
| Vermont | 24 | 11 | 8 | 4.0 | 1.9 | 1.3 |
| MIDEAST | | | | | | |
| Delaware | 185 | 172 | 124 | 17.0 | 14.7 | 9.8 |
| Maryland | 482 | 178 | 136 | 8.8 | 3.0 | 2.1 |
| New Jersey | 411 | 1 | 181 | 3.6 | 0.0 | 1.5 |
| New York | 0 | 0 | 0 | 0.0 | 0.0 | 0.0 |
| Pennsylvania* | 497 | 263 | 139 | 4.5 | 2.2 | 1.1 |
| GREAT LAKES | | | | | | |
| Illinois | 541 | 395 | 275 | 4.6 | 3.0 | 2.0 |
| Indiana | 690 | 690 | 492 | 13.8 | 12.5 | 8.2 |
| Michigan | 480 | 391 | 441 | 6.8 | 5.4 | 5.8 |
| Ohio | 815 | 810 | 439 | 9.2 | 8.6 | 4.3 |
| Wisconsin | 375 | 243 | 99 | 6.9 | 4.2 | 1.6 |
| PLAINS | | | | | | |
| Iowa | 95 | 71 | 1 | 3.6 | 2.5 | 0.0 |
| Kansas | 371 | 270 | 127 | 17.2 | 11.3 | 5.1 |
| Minnesota | 946 | 828 | 532 | 15.9 | 12.5 | 7.4 |
| Missouri | 110 | 57 | 47 | 2.9 | 1.4 | 1.1 |
| Nebraska | 340 | 299 | 148 | 34.5 | 25.0 | 10.0 |
| North Dakota | 65 | 75 | 61 | 11.9 | 14.2 | 12.2 |
| South Dakota | 39 | 38 | 11 | 9.4 | 8.6 | 2.3 |
| SOUTHEAST | | | | | | |
| Alabama | 74 | 97 | -47 | 2.3 | 3.0 | -1.3 |
| Arkansas | 0 | 0 | 0 | 0.0 | 0.0 | 0.0 |
| Florida | 199 | 240 | 228 | 2.1 | 2.4 | 2.0 |
| Georgia | 433 | 37 | 37 | 6.8 | 0.5 | 0.5 |
| Kentucky | 48 | 87 | 202 | 1.4 | 2.5 | 4.7 |
| Louisiana | 655 | 546 | 199 | 16.3 | 12.4 | 4.4 |
| Mississippi | 108 | 26 | -32 | 6.0 | 1.4 | -1.6 |
| North Carolina | 157 | 222 | 141 | 2.4 | 3.2 | 1.8 |
| South Carolina | 146 | 109 | 115 | 4.7 | 3.3 | 3.2 |
| Tennessee | 228 | 165 | 100 | 6.7 | 4.4 | 2.6 |
| Virginia | 0 | 0 | -556 | 0.0 | 0.0 | -8.4 |
| West Virginia | 66 | 100 | 0 | 4.5 | 5.8 | 0.0 |
| SOUTHWEST | | | | | | |
| Arizona | 1 | 6 | 14 | 0.0 | 0.2 | 0.4 |
| New Mexico | 113 | 108 | 107 | 6.4 | 5.9 | 5.5 |
| Oklahoma | 309 | 298 | 346 | 12.1 | 11.0 | 11.6 |
| Texas | 297 | 550 | 75 | 2.3 | 3.7 | 0.5 |
| ROCKY MOUNTAIN | | | | | | |
| Colorado | 135 | 111 | 44 | 5.7 | 4.4 | 1.6 |
| Idaho | 89 | 84 | 52 | 12.5 | 9.5 | 5.7 |
| Montana | 67 | 85 | 67 | 17.3 | 19.7 | 14.8 |
| Utah | 119 | 104 | 108 | 7.9 | 6.4 | 6.4 |
| Wyoming | 112 | 51 | 65 | 29.0 | 11.8 | 17.7 |
| FAR WEST | | | | | | |
| Alaska | 163 | 268 | 283 | 7.2 | 10.9 | 10.9 |
| California | 1,109 | * 694 | 1,578 | 3.1 | 1.7 | 3.8 |
| Hawaii | 629 | 456 | 313 | 28.2 | 17.0 | 11.1 |
| Nevada | 67 | 110 | 95 | 8.9 | 14.4 | 10.8 |
| Oregon | 296 | 311 | 306 | 15.2 | 14.1 | 12.8 |
| Washington | 516 | 771 | 645 | 9.0 | 12.1 | 9.5 |
| TOTAL | $12,538 | $9,082 | $7,412 | 4.8 % | 3.3 % | 2.5 % |
| District of Columbia | -217 | -217 | -217 | -7.6 | -7.0 | -6.7 |

## COST ESTIMATES OF ENACTED FEDERAL MEDICAID EXPANSIONS
## STATE FISCAL YEAR 1991
### (STATE-ONLY DOLLARS IN MILLIONS)

| STATE | Welfare Reform (Medicaid) | Medicare Catastroph. Coverage | Nursing Home Reform | Pregnant Women & Infants to 133% Poverty | Children to Age 6 to 133% Poverty | 1990 EPSDT Changes | Total Cost Of Expansions |
|---|---|---|---|---|---|---|---|
| ALABAMA | $0.6 | $11.5 | $2.3 | $4.5 | $3.5 | N.A. | $22.4 |
| ALASKA | 2.1 | 0.0 | 0.0 | N.A. | N.A. | 0.9 | 3.0 |
| ARIZONA | 6.3 | 10.8 | 0.2 | 6.3 | 6.2 | 7.9 | 37.7 |
| ARKANSAS | 12.0 | 17.0 | 1.3 | 8.2 | 3.4 | 1.9 | 43.8 |
| CALIFORNIA | 4.3 | 80.6 | 143.0 | 0.0 | 1.6 | 0.0 | 229.5 |
| COLORADO | 0.7 | 3.2 | 2.6 | 5.3 | 5.1 | N.A. | 16.9 |
| CONNECTICUT | 0.6 | 9.0 | 2.5 | 0.0 | 1.1 | 1.0 | 14.2 |
| DELAWARE | 0.5 | 0.0 | 0.7 | 1.5 | 0.2 | 0.6 | 3.5 |
| DISTRICT OF COLUMBIA | 0.0 | 0.0 | 0.8 | 0.0 | 0.9 | 0.0 | 1.7 |
| FLORIDA | 7.5 | 37.4 | N.A. | 0.0 | 4.8 | 34.8 | 84.5 |
| GEORGIA | 2.6 | 17.7 | 13.2 | 17.7 | 14.7 | 3.6 | 69.6 |
| HAWAII | N.A. | 6.4 | N.A. | 0.0 | 1.2 | N.A. | 7.6 |
| IDAHO | 0.3 | 2.3 | 1.6 | 2.9 | 5.3 | 0.4 | 12.8 |
| ILLINOIS | 14.6 | 46.0 | 68.3 | 6.6 | 6.8 | 10.0 | 152.3 |
| INDIANA | 23.5 | 73.1 | 2.5 | 4.5 | 9.5 | N.A. | 113.1 |
| IOWA | (1.5) | 27.4 | 4.0 | 0.0 | 0.2 | N.A. | 30.0 |
| KANSAS | 0.7 | 1.4 | 1.2 | 1.3 | 1.3 | 4.0 | 9.9 |
| KENTUCKY | 3.7 | 11.4 | 5.5 | 0.9 | 2.8 | 2.8 | 27.1 |
| LOUISIANA | 2.6 | 5.0 | 7.8 | 0.0 | 0.0 | 4.6 | 20.0 |
| MAINE | 1.5 | 4.4 | 1.5 | 0.0 | 0.0 | 0.0 | 7.4 |
| MARYLAND | 2.7 | 8.6 | 0.7 | 0.0 | 6.8 | 5.3 | 24.1 |
| MASSACHUSETTS | 7.0 | 67.5 | 15.5 | 0.0 | 7.0 | 3.5 | 100.5 |
| MICHIGAN | 1.6 | 25.1 | 9.4 | 0.0 | 5.8 | 0.0 | 41.9 |
| MINNESOTA | 3.1 | 18.7 | 2.1 | 0.0 | 2.8 | 0.0 | 26.7 |
| MISSISSIPPI | 8.0 | 15.0 | 0.0 | 0.5 | 0.5 | 2.0 | 26.0 |
| MISSOURI | 4.0 | 14.5 | 3.4 | 5.0 | 0.9 | 5.3 | 33.0 |
| MONTANA | 0.4 | 4.5 | 0.8 | 0.7 | 0.4 | 3.5 | 10.4 |
| NEBRASKA | 0.6 | 4.1 | 5.5 | 2.5 | 0.2 | 2.3 | 15.2 |
| NEVADA | N.A. | N.A. | N.A. | N.A. | N.A. | N.A. | N.A. |
| NEW HAMPSHIRE | 0.0 | 5.1 | 3.5 | 1.6 | 0.6 | 1.0 | 11.8 |
| NEW JERSEY | 1.0 | 35.7 | 12.1 | 6.6 | 6.0 | 0.0 | 61.4 |
| NEW MEXICO | 1.6 | (0.7) | 0.9 | 0.7 | 2.1 | 3.1 | 7.7 |
| NEW YORK | 2.1 | 137.8 | 3.8 | 0.0 | 4.7 | 0.0 | 148.4 |
| NORTH CAROLINA | 3.2 | 7.3 | 13.4 | 9.1 | 0.3 | 0.6 | 33.9 |
| NORTH DAKOTA | 0.7 | 0.5 | 1.6 | 0.7 | 1.2 | 0.0 | 4.6 |
| OHIO | 8.9 | 20.6 | 25.6 | 18.1 | 9.2 | 0.0 | 82.5 |
| OKLAHOMA | 3.4 | 8.3 | 3.5 | 3.8 | 3.1 | N.A. | 22.1 |
| OREGON | 2.8 | 2.9 | 0.7 | 10.3 | 1.4 | 6.7 | 24.9 |
| PENNSYLVANIA | 11.9 | 31.3 | 1.4 | 9.2 | 8.8 | 1.0 | 63.6 |
| RHODE ISLAND | 0.5 | 2.5 | 0.5 | 0.0 | 0.1 | 0.0 | 3.6 |
| SOUTH CAROLINA | 1.5 | 12.2 | 1.6 | 0.0 | 1.2 | 8.0 | 24.5 |
| SOUTH DAKOTA | 0.5 | 1.2 | 0.2 | 1.2 | 0.9 | 0.7 | 4.6 |
| TENNESSEE | 5.4 | 34.6 | 1.2 | 0.0 | 4.9 | N.A. | 46.1 |
| TEXAS | 34.5 | 51.7 | 53.5 | 0.3 | 16.4 | 13.3 | 169.7 |
| UTAH | 0.5 | 1.8 | 3.1 | 1.2 | 0.8 | 0.3 | 7.7 |
| VERMONT | 0.1 | 0.6 | 0.8 | 0.0 | 0.2 | N.A. | 1.7 |
| VIRGINIA | 5.1 | 10.0 | 1.8 | 14.8 | 5.4 | 25.5 | 62.6 |
| WASHINGTON | 1.1 | 14.7 | 22.7 | 0.0 | 1.6 | 8.6 | 48.7 |
| WEST VIRGINIA | 0.6 | 6.8 | 3.5 | 0.0 | N.A. | 0.0 | 10.9 |
| WISCONSIN | 3.9 | 8.5 | 9.1 | 3.8 | 2.8 | N.A. | 28.1 |
| WYOMING | 0.0 | 0.4 | 0.5 | 0.3 | 0.8 | 0.2 | 2.3 |
| TOTAL | $199.3 | $916.6 | $461.3 | $150.1 | $165.5 | $163.5 | $2,056.3 |

N.A. = NOT AVAILABLE

Source: National Association of State Budget Officers, October 19, 1990.

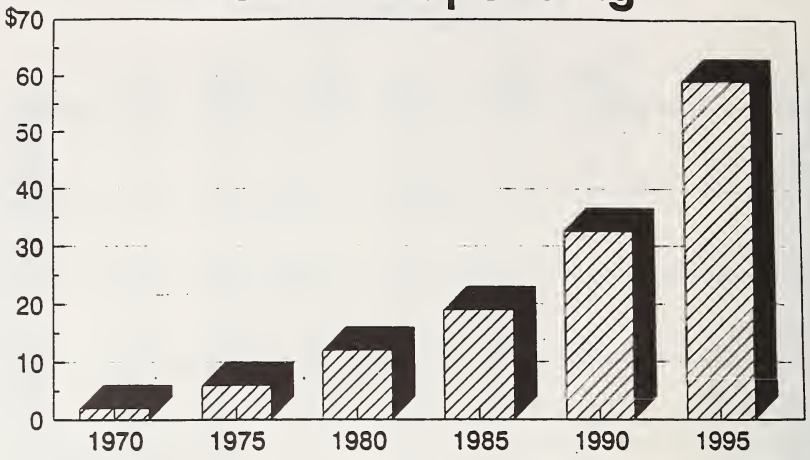
## COST ESTIMATES OF ENACTED FEDERAL MEDICAID EXPANSIONS
## STATE FISCAL YEAR 1992
### (STATE-ONLY DOLLARS IN MILLIONS)

| STATE | Welfare Reform (Medicaid) | Medicare Catastroph. Coverage | Nursing Home Reform | Pregnant Women & Infants to 133% Poverty | Children to Age 6 to 133% Poverty | 1990 EPSDT Changes | Total Cost Of Expansions |
|---|---|---|---|---|---|---|---|
| ALABAMA | $1.0 | $13.2 | $2.5 | $5.7 | $3.8 | N.A. | $26.2 |
| ALASKA | N.A. | N.A. | N.A. | N.A. | N.A. | N.A. | N.A. |
| ARIZONA | 7.4 | 11.9 | 0.5 | 7.9 | 7.8 | 20.8 | 56.3 |
| ARKANSAS | 14.0 | 18.0 | 2.9 | 8.4 | 3.7 | 2.6 | 49.6 |
| CALIFORNIA | 5.9 | 154.4 | 229.3 | 0.0 | 1.8 | 0.0 | 391.4 |
| COLORADO | 1.0 | 3.8 | 2.6 | 5.9 | 5.6 | N.A. | 18.9 |
| CONNECTICUT | 0.7 | 11.0 | 4.5 | 0.0 | 4.0 | 6.5 | 26.7 |
| DELAWARE | 0.5 | 0.0 | 0.7 | 1.7 | 0.3 | 1.2 | 4.4 |
| DISTRICT OF COLUMBIA | 0.0 | 0.0 | 0.8 | 0.0 | 0.9 | 0.0 | 1.7 |
| FLORIDA | 8.0 | 39.6 | N.A. | 0.0 | 20.6 | 44.2 | 112.4 |
| GEORGIA | 3.1 | 26.1 | 16.3 | 21.4 | 26.1 | 3.9 | 96.8 |
| HAWAII | N.A. | 6.4 | N.A. | 0.0 | 1.2 | N.A. | 7.6 |
| IDAHO | 0.4 | 3.0 | 1.8 | 3.3 | 6.1 | 0.5 | 15.1 |
| ILLINOIS | 17.3 | 51.3 | 102.4 | 12.7 | 14.0 | 10.8 | 208.5 |
| INDIANA | 26.3 | 82.0 | 2.8 | 5.0 | 10.7 | N.A. | 126.8 |
| IOWA | (2.2) | 32.2 | 4.0 | 0.0 | 0.2 | N.A. | 34.2 |
| KANSAS | 1.0 | 1.8 | 1.2 | 1.6 | 1.6 | 4.4 | 11.6 |
| KENTUCKY | 7.5 | 12.0 | 5.5 | 1.5 | 5.0 | 3.5 | 35.1 |
| LOUISIANA | 2.7 | 5.2 | 8.2 | 0.0 | 0.0 | 4.9 | 21.0 |
| MAINE | 1.5 | 4.7 | 2.4 | 0.0 | 0.0 | 0.0 | 8.6 |
| MARYLAND | 2.9 | 10.8 | 0.8 | 0.0 | 7.5 | 5.8 | 27.8 |
| MASSACHUSETTS | N.A. | N.A. | N.A. | N.A. | N.A. | N.A. | N.A. |
| MICHIGAN | 3.5 | 65.8 | 9.4 | 0.0 | 6.4 | 0.0 | 85.1 |
| MINNESOTA | 4.0 | 20.1 | 2.1 | 0.0 | 4.4 | 0.0 | 30.6 |
| MISSISSIPPI | 10.0 | 25.0 | 0.0 | 1.0 | 1.0 | 3.0 | 40.0 |
| MISSOURI | 4.7 | 20.7 | 3.4 | 17.1 | 2.6 | 8.5 | 57.0 |
| MONTANA | 0.5 | 4.6 | 0.9 | 0.7 | 0.5 | 6.0 | 13.2 |
| NEBRASKA | 0.7 | 5.6 | 6.2 | 2.8 | 0.2 | 2.5 | 18.0 |
| NEVADA | N.A. | N.A. | N.A. | N.A. | N.A. | N.A. | N.A. |
| NEW HAMPSHIRE | 0.0 | 3.7 | 5.3 | 1.7 | 0.8 | 1.1 | 14.6 |
| NEW JERSEY | 1.1 | 43.7 | 13.3 | 7.3 | 6.7 | 0.0 | 72.1 |
| NEW MEXICO | 1.7 | (0.7) | 0.9 | 0.7 | 2.2 | 3.5 | 8.3 |
| NEW YORK | 4.2 | 151.6 | 4.6 | 0.0 | 14.0 | 0.0 | 174.4 |
| NORTH CAROLINA | 3.6 | 8.2 | 14.8 | 10.0 | 1.0 | 0.8 | 38.4 |
| NORTH DAKOTA | 0.7 | 0.6 | 1.7 | 0.7 | 1.2 | 0.0 | 4.9 |
| OHIO | 9.5 | 21.9 | 59.1 | 18.1 | 9.2 | 0.0 | 117.9 |
| OKLAHOMA | 3.7 | 9.3 | 4.9 | 3.8 | 3.1 | N.A. | 24.8 |
| OREGON | 4.7 | 3.1 | 2.3 | 11.9 | 1.9 | 7.1 | 30.9 |
| PENNSYLVANIA | 12.4 | 31.8 | 1.5 | 10.0 | 14.4 | 1.0 | 71.1 |
| RHODE ISLAND | 0.8 | 2.7 | 0.5 | 0.0 | 0.1 | 0.0 | 4.1 |
| SOUTH CAROLINA | 1.9 | 13.4 | 1.7 | 0.0 | 1.5 | 8.4 | 26.9 |
| SOUTH DAKOTA | 0.5 | 1.2 | 0.3 | 1.2 | 0.9 | 0.7 | 4.8 |
| TENNESSEE | 5.7 | 38.1 | 1.3 | 0.0 | 4.9 | N.A. | 50.0 |
| TEXAS | 46.3 | 56.8 | 55.1 | 0.4 | 17.7 | 14.3 | 190.5 |
| UTAH | 0.8 | 2.4 | 5.1 | 1.3 | 1.4 | 1.0 | 12.0 |
| VERMONT | 0.1 | 1.1 | 1.3 | 0.0 | 0.2 | N.A. | 2.8 |
| VIRGINIA | 9.3 | 19.3 | 1.8 | 19.7 | 10.6 | 27.5 | 88.2 |
| WASHINGTON | 1.3 | 16.0 | 28.2 | 0.0 | 1.9 | 10.0 | 57.4 |
| WEST VIRGINIA | 0.8 | 7.5 | 3.8 | 0.0 | N.A. | 0.0 | 12.1 |
| WISCONSIN | 3.9 | 8.5 | 9.1 | 4.3 | 5.6 | N.A. | 31.4 |
| WYOMING | 0.0 | 1.0 | 0.5 | 0.4 | 0.8 | 0.3 | 3.0 |
| TOTAL | $235.2 | $1,072.5 | $628.1 | $188.4 | $236.1 | $204.7 | $2,565.1 |

N.A. = NOT AVAILABLE

Source: National Association of State Budget Officers, October 19, 1990.

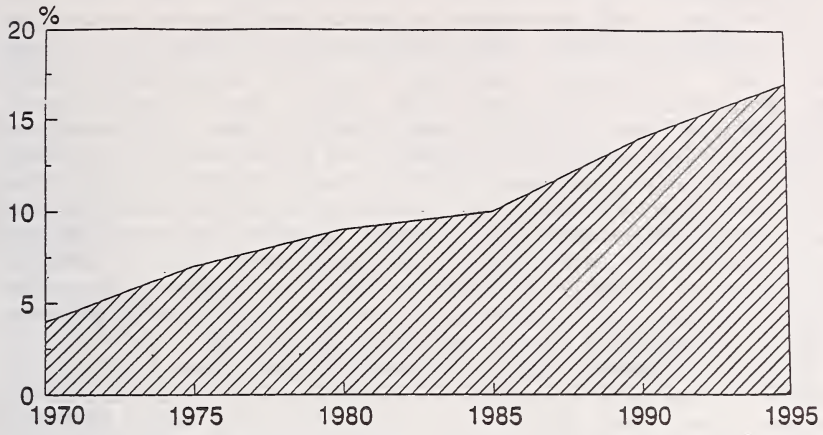
# Medicaid Spending




*$33 Billion state expenditures in 1990 going to $59 Billion in 1995

*211% spending increase from 1985 to 1995

## Medicaid Spending as a Percent of State Budgets




*10% of State Budgets in 1985
*14% of State Budgets in 1990
*17% of State Budgets in 1995

Mr. WEISS. And you have described in general terms the costs of Medicaid programs contributed to State budgetary shortfalls. Can you quantify that at all? Is that the $16 million and $5 million you quoted to us?

Mr. CLINTON. Yes. In order for us to fund the existing mandates, not counting the OBRA 1990 mandates, for the remainder of this fiscal year, we thought we had done through a combination of management, administrative reductions, hiring freeze, travel freeze, eliminating some regulatory operations in the department of human services, and the elimination of the services I just mentioned, we understand estimated the cost of the mandates, so we now have to come back and get another $16 million, which means we have to cut the blood and life out of all of our optional Medicaid programs, or we have to get the legislature to give us another equivalent of a total of 1 percent of the State budget to spend between now and July 1, and we are working on that now in preparation of the legislative session beginning January 16.

But our situation in Arkansas is not different from a lot of other States. We have more Medicaid eligibles than most States, because we are a poor State. But we also, to be fair, get a better Medicaid match. So, States with relatively fewer Medicaid eligibles have to pay a bigger match, and therefore the financial burdens pretty well even out, I think.

Mr. WEISS. There are, as you more than know, as many as 37 million Americans with no health care coverage at all, and 11 million of them live in poverty. I know this goes somewhat on the narrow aspects of this hearing, but if we can't reach them through expansion in the Medicaid program, where is your sense of how we should deal with this problem?

Mr. CLINTON. Excuse me. This may seem contradictory, but we might want to reach some of them through expansions of Medicaid. The Governors' position, however, is if we want to reach them through expansions of Medicaid, we need to come up with a long-term strategy to solve the coverage problem, which may include expansions of Medicaid, mandated employer coverage, or some other government backup program.

We need to play it all before the people, as well as the funding mechanism to pay for it, so that we can all be part of solving a problem that is very comprehensive in nature, and I think serves a more comprehensive solution.

If we want to create a children's trust fund, if we want to say our social security depends as much on taking care of our kids as taking care of our elderly, and we should do both, then we ought to develop a Federal compact to do that. And if the States have to raise money and pay for it, fine, but it ought to be a stated, deliberate, public and highly debated policy that the taxpayers understand and that the people understand.

The point I am trying to make now, what they are doing by incrementally putting these mandates on, is basically having Congress make national health care policy to eliminate, as well as increase Medicaid services in ways that may or may not be good from State to State, depending on the facts of the State.

By doing it a little along, and without a lot of clear public direction as to where we are going to end up, inevitably forcing the

States to reduce their investment in education, primarily, in order to fund the Medicaid mandate, because most States, as you know, have only raised taxes in the 1980's for specific school programs or road programs, and there have been very, very few general tax increases in the 1980's in the States—things that now will be even more difficult.

So I think if this strategy is to maximize Medicaid coverage for kids, so that you can enable, for example their employers, the employers of their parents to cover them at lower cost; and there will be a compact between the government and private sector to mandate more employer coverage, but to take care of a lot of their kids through expanded Medicaid—which you do, by the way, inevitably, if you go to 185 percent of the Federal poverty level you are covering most of the working women and working families in my State.

And the good news is that you will lower the health care costs of a lot of private employers, and you may make it economically possible for other employers to undertake the insurance of their employees when they didn't before. But that hasn't been part of the bargain or the mix.

It hasn't—one of the things that I think should be done, for example, is somebody should do an estimate of how many children will be eligible for Medicaid coverage who were previously under private insurance policies of their parents. And is it a good or a bad thing for those kids to be covered by and paid for by Medicaid, as opposed to private insurance policies.

And if you are doing that, does it make it now more palatable to the business community and our country to have some sort of employer mandate for coverage of the adults if you are taking care of the kids? Because that provides economic protection to small business that wasn't there before. That makes them so afraid of mandated national health benefits you have a whole laundry list of questions that need to be asked.

I guess what I would say is I want to maximize Medicaid coverage of women and children. If we can't prove we can do as good a job as any other country in bringing children into the world healthy and get them to school, and safe to learn physically and emotionally, we are done for.

I have no problem with the policy which antedated these decisions. But look at the practical impact of the policy, and to undermine the companion policy that States should be following, to educate these children as we bring them into the world and take care of them. And does not say anything about where we are going to wind up when it is all over. And doesn't deal with the inevitable reduction in the Medicaid services, which States on limited budgets are going to have. Do you want that or not?

And I can tell you my own philosophy in my State is we ought to do everything we can to maximize Medicaid, because we get the second best match in the country. I am here speaking for all the Governors, if we could work it out somehow, Arkansas, Mississippi, and Louisiana, and a few of us might benefit by maximizing Medicaid dollars.

The points I have made are still valid for a State as a whole, and therefore for the country.

Mr. Weiss. Well, I thank you very much, Governor.

I think that you have the broad overview that I think has to be the way we address this problem. We can't really do it piecemeal. I hope this coming Congress we will be looking at it in a much more comprehensive way. The devil take the hindmost kind of approach we have been using so far, obviously, just creating chaos every place, and at this point with an economic recession that we are in the midst of, we are only going to grow worse trying to.

I think the States desperately need help. The information that we start getting now from some of our people who are working on the legislative aspects of some of these proposals, that we are spending far more than is necessary, nationwide, in private and public ways then would be necessary to really get a good system.

In fact, we don't have a good system. We have a rotten system. There are far too many people who aren't covered. Your input and your continued involvement will be very important as we go forward in this effort, and I thank you very, very much for your participation and leadership.

Thank you very much.

Our final witness is the Honorable Gail Wilensky.

Dr. Wilensky, welcome. We have your prepared statement. And, of course, it will be entered into the record in its entirety and you may feel free to deliver it as you prepared it, or using it as a take-off point. Whatever is most appropriate.

**STATEMENT OF GAIL R. WILENSKY, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Dr. WILENSKY. Thank you. I am pleased to be here today to discuss the Medicaid program.

Over the past 25 years, the Medicaid program has been successful in providing access to health care for our Nation's most vulnerable citizens. Medicaid continues to ensure that quality care is available to an increasing number of eligible individuals in a wide range of care settings.

In fiscal year 1990 Federal Medicaid spending totaled $41 billion, an increase of 19 percent from the previous year. States spent an estimated $31 billion to pay for services provided to 26 million Medicaid recipients.

Domestic spending across the Nation is at an all-time high, and State governments are striving to balance budgets and control costs. The Medicaid program is consuming increasingly larger portions of these budgets and was the second largest State spending category in fiscal year 1990. We in the Federal Government as well as States are exploring ways to better contain program costs while maintaining the quality of care for Medicaid recipients.

States will need to consider creative ways to fund the Medicaid program at the level necessary to meet the health care needs of their vulnerable populations. We are ready to work with them as they put forward new ideas for positive, innovative changes.

One of the first things I did as HCFA Administrator was to establish a new Medicaid Bureau with concrete initiatives to promote increased access to services, quality of care for recipients and better program management. The increased visibility of this new

organization provides an important focal point for the public and private sectors to address Medicaid issues.

It is important to remember that Medicaid is a joint Federal/State endeavor. Medicaid is not a single, uniform program, but comprises 50 individual State programs. We would seriously question any attempt to mandate uniformity on States, when their demographic and economic circumstances are so diverse.

Given that both Federal and State resources are scarce, it is critical that we move toward a system that not only cuts costs, but promotes value.

In particular, States are encouraged to use coordinated care programs to better manage available resources and target services to specific groups. Health maintenance organizations and other prepaid health care plans offer a comprehensive range of services and provide ready access to necessary care.

To date, 23 States have implemented successful coordinated care programs with an enrollment of over 2 million Medicaid recipients.

Recent legislation has taken several important steps toward ensuring that Medicaid gets better value for its dollar. For example, the new Medicaid prescription drug provisions will save the Federal Government about $1.9 billion and State governments $1.4 billion over the next 5 years. The drug provisions recognize the buying power of Medicaid and bring Medicaid more in line with other major prudent purchasers of prescription drugs.

We are also involved in a number of outreach efforts to identify Medicaid eligibles and maximize access to necessary care.

Our maternal and infant health initiative assists States to enroll pregnant women in prenatal care programs. We are coordinating our activities at both Federal and State levels to target outreach to women and streamline eligibility.

We also encourage States to use targeted case management services to coordinate access to services.

We are working with the American College of Obstetricians and Gynecologists and the Public Health Service to help State Medicaid agencies improve the recruitment and retention of obstetrical providers.

All of these initiatives will improve services to Medicaid recipients.

Rather than consider further program expansions, however, we should ensure that resources are available to care for currently eligible individuals.

The recent Medicaid expansions to include new groups of pregnant women and children add millions of recipients and over $6 billion in Federal and State spending over the next 5 years. States need time to organize and implement these and other congressional mandates.

I want to clarify that the Federal Government is not involved in the establishment of State payment methodologies for Medicaid services.

The law permits States to establish their own payment levels for services consistent with economy, efficiency, and quality of care.

As with the level of payment rates, there has been some discussion about the adequacy of Federal Medicaid matching rates. The extent to which Federal Medicaid matching rates allow States to

operate effective programs has been examined periodically by various groups.

Alternative formulas for Medicaid matching have been recommended. However, any changes within a budget neutral context could result in a significant redistribution of Federal funds with resultant "winners and losers."

As is the case with most aspects of Medicaid, the primary responsibility for ensuring quality of care rests with the States. The Federal role is one of oversight and monitoring.

We have undertaken a major study to look at quality of care in the Medicaid program. During phase I of the study, we looked at the utilization of over 160 inpatient and outpatient procedures in the Medicaid and non-Medicaid populations. Preliminary results indicate that, overall, utilization was higher in the Medicaid population.

Phase II of the study will examine treatment effectiveness, preventable morbidity and mortality, and pregnancy outcomes.

Medicaid has achieved its goal of providing care for the most vulnerable and indigent. We must remember, however, that the Medicaid program was not established to provide health insurance coverage for all the Nation.

The administration is concerned about those Americans without adequate health insurance coverage. As Vice Chair of Secretary Sullivan's Task Force on the Uninsured, I am actively involved with the White House Domestic Policy Council work group studying this subject.

I have every confidence that States can continue to serve their vulnerable populations despite demands on limited resources. It is my priority to see that States receive every assistance available from HCFA to ensure quality care for all Medicaid recipients.

I would be glad to answer any questions you may have.

[The prepared statement of Dr. Wilensky follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C. 20201

STATEMENT OF

GAIL R. WILENSKY, PH.D.

ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE

OF THE

COMMITTEE ON GOVERNMENT OPERATIONS

HOUSE OF REPRESENTATIVES

DECEMBER 7, 1990

Mr. Chairman and Members of the Subcommittee, I am pleased to be here today to discuss the Medicaid program.

Over the past 25 years, the Medicaid program has been successful in providing access to health care for our nation's most vulnerable citizens. Medicaid continues to ensure that quality care is available to an increasing number of eligible individuals in a wide range of care settings.

**BACKGROUND**

In fiscal year 1990 Federal Medicaid spending totaled $41 billion, an increase of 19 percent from the previous year. States spent an estimated $31 billion to pay for services provided to 26 million Medicaid recipients.

Domestic spending across the nation is at an all-time high, and State governments are striving to balance budgets and control costs. The Medicaid program is consuming increasingly larger portions of these budgets and was the second largest State spending category in fiscal year 1990. We in the Federal government as well as States are exploring ways to better contain program costs while maintaining the quality of care for Medicaid recipients.

States will need to consider creative ways to fund the

Medicaid program at the level necessary to meet the health care needs of their vulnerable populations. We are ready to work with them as they put forward new ideas for positive, innovative changes.

One of the first things I did as HCFA Administrator was to establish a new Medicaid Bureau with concrete initiatives to promote increased access to services, quality of care for recipients and better program management. Improving the timeliness and quality of the HCFA regulations clearance process was among our first accomplishments. The increased visibility of this new organization provides an important focal point for the public and private sectors to address Medicaid issues.

It is important to remember that Medicaid is a joint Federal/State endeavor. Medicaid is **not** one simple, uniform program, but comprises 50 independent State programs.

States have considerable flexibility, within Federal rules, to determine eligibility, to decide the amount, duration, and scope of services they will cover, and to establish payment rates for those services. Giving States primary responsibility for administering their unique programs is both appropriate and reasonable. And, we would seriously question any attempt to mandate uniformity on States, when their demographic and economic circumstances are so diverse.

**BETTER VALUE FOR OUR MEDICAID DOLLARS**

Given that both Federal and State resources are scarce, it is critical that we move toward a system that not only cuts costs, but also promotes value. Value occurs when consumers and providers have the information necessary to make informed decisions. Value also occurs when better incentives lead to greater efficiency.

At the Federal level, we are promoting initiatives that provide better value for our Medicaid dollars. In particular, States are encouraged to use coordinated care programs to better manage available resources and target services to specific groups. Health maintenance organizations and other prepaid health care plans provide a comprehensive range of services. They also coordinate care so that patients have ready access to necessary services and avoid unnecessary or duplicative services.

To date, twenty-three States have implemented successful coordinated care programs with an enrollment of over 2.0 million Medicaid recipients.

Recent legislation has taken several important steps to ensure that the Medicaid program is getting better value for its dollar. OBRA 90 will save the Federal government about $1.9 billion and State governments $1.4 billion in Medicaid prescription drug costs over the next five years. The drug

provision recognizes the buying power of Medicaid and helps bring Medicaid drug payments into line with what other major prudent purchasers are spending.

The new drug law represents an attempt to maintain balance among several important objectives. Budgetary savings have been realized, while needed medicines remain accessible to the poor and elderly. This compromise preserves the physician/patient relationship and the unique Federal/State partnership that defines the Medicaid program. This is an excellent first step toward better management of both Federal and State tax dollars in this area.

Another OBRA 90 provision directs States to purchase private group health insurance for Medicaid recipients if it is cost-effective to do so. This represents the kind of public-private partnership we need in dealing with the health care problems of the poor and near poor.

**IMPROVING OUTREACH**

We are also involved in a number of Medicaid outreach efforts that identify Medicaid eligibles and maximize access to necessary care.

Our Maternal and Infant Health Initiative assists States to enroll pregnant women in prenatal care programs. We are

coordinating our activities at both Federal and State levels with the Public Health Service's maternal and child health program and with the Agriculture Department's Women, Infants and Children program which provides infant formula and nutritional guidance. This effort has been underway since 1989 and has been instrumental in targeting outreach to women, streamlining eligibility, and implementing case management programs.

We also encourage States to use targeted case management services. Such services allow States to coordinate access to services to improve the care of Medicaid recipients. There is no limit to the number of target groups to which a State may furnish this optional service. Many States have targeted the developmentally disabled, the chronically mentally ill, pregnant women, medically fragile children, persons with AIDS, and the functionally disabled elderly.

Home and community based waivers allow States to provide services to individuals who would otherwise require institutionalized care. HCFA is involved in an effort to streamline the application process for home and community based waivers. The streamlined waiver format will both standardize and expedite the application process.

We also have entered into an agreement with the American College of Obstetricians and Gynecologists and the Public Health

Service to assist State Medicaid agencies in improving the recruitment and retention of obstetrical providers. Jointly, we are addressing such issues as payment levels and procedures; professional liability; provider relations; and the development of practice guides to assist providers in Medicaid participation. We expect to distribute these guides by the end of January, 1991.

We anticipate these initiatives will have substantial impact on improved service to Medicaid recipients. Rather than consider further program expansions, however, we should ensure that resources are available to care for currently eligible individuals. States need time to adjust to the numerous Congressional mandates over the last five years -- time to organize and to implement recent program expansions effectively.

**MEDICAID COVERAGE**

Medicaid was originally designed to provide medical assistance to the Nation's most vulnerable citizens -- families with dependent children and the aged, blind, or disabled -- whose income and resources are insufficient to meet the costs of necessary medical services.

Individuals receiving cash welfare benefits -- Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) -- are still the majority of Medicaid beneficiaries. Eligibility for AFDC applicants is determined primarily by the

rules and benefit levels of the 57 State and territorial programs. Eligibility for SSI applicants is determined primarily by a single Federal formula.

In recent years, expansions in the Medicaid program to include new eligibility groups of pregnant women and children have added millions of recipients and billions of dollars to State programs. Expansions mandated by the Omnibus Budget Reconciliation Acts of 1989 and 1990 (OBRA 89 and 90) alone will ultimately make several million additional pregnant women and children eligible for Medicaid and are expected to increase Federal/State spending by $6 billion over the next five years.

OBRA 89 and 90 also mandated demonstration projects for additional groups not otherwise eligible for assistance. We have recently selected Maine, Florida, and Michigan to demonstrate expanding Medicaid eligibility by extending coverage to pregnant women and children under age 20 in families with incomes below 185 percent of the Federal poverty level. Employers are encouraged to become involved in funding participants' coverage, and premiums are charged on a sliding scale for families with incomes above the Federal poverty level. These demonstrations will run over a three-year period, with a maximum of $10 million each year in Federal matching funds.

Demonstration projects targeted to individuals in families

with incomes above current State eligibility levels regardless of maternal status will be conducted in 3 or 4 States. These projects will start in mid-1991 and will run for a three-year period.

**PAYMENT STRATEGIES**

These and other new mandates will result in more Medicaid recipients and higher Medicaid budgets. Meanwhile, double-digit increases in Medicaid spending continue to outpace the growth of overall State spending. According to the National Association of State Budget Officers, Medicaid expenditures have increased as a percentage of total State expenditures from 10 percent in FY 1987 to 12 percent in FY 1990.

This financial pressure demands innovative strategies from States to meet Congressional mandates. We must, of course, keep in mind that all the economic pressures the States experience also affect the Federal government. The national economy is, afterall, nothing more than a composite of the individual State economies.

States have developed several prudent purchaser strategies including: competitive bidding; volume/bulk purchasing; and selective contracting. At least 16 States use competitive bidding and volume purchasing arrangements, primarily for optical services, hearing aids, vaccines, and prescription drugs.

Savings achieved for these programs range from one-third to one-half of previous expenditures.

I want to clarify that the Federal government is not involved in the establishment of State payment methodologies for Medicaid services. The law permits States to establish their own payment levels for services consistent with economy, efficiency, and quality of care.

State payment levels for physician services must be sufficient to enlist enough providers to ensure access to services to the extent that care is available to the general population; and, payment rates for hospitals and nursing facilities are subject to certain upper limits. We are responsible for reviewing States' plans to ensure that they satisfactorily meet these conditions.

As with the level of payment rates, there has been some discussion about the adequacy of Federal Medicaid matching rates. The extent to which Federal Medicaid matching rates allow States to operate effective programs has been examined periodically by the General Accounting Office, the Office of the Inspector General, and HCFA. The existing matching formula takes into account variations in State wealth through the use of per capita income.

The combined effect of the formula and current expenditures has increased the average Federal match from 55 to 57 percent between 1984 and 1991. This increases the projected Federal contribution in FY 91 by nearly $2 billion.

Alternative formulas for Medicaid matching have been recommended. However, any changes within a budget neutral context could result in a significant redistribution of Federal funds with resultant "winners and losers."

**QUALITY**

As is the case with most aspects of Medicaid, the primary responsibility for ensuring quality of care rests with the States. The Federal role is one of oversight and monitoring. We review the adequacy of State plans in meeting several requirements for ensuring the quality of Medicaid services, including, for example, requirements for licensing of practitioners; reliance on professional organizations such as medical societies; use of peer review organizations; and the establishment of State Medicaid Fraud Control Units.

We have undertaken a major study to look at quality of care in the Medicaid program. Our Office of Research and Demonstrations is conducting a multifaceted project that includes studies of the appropriateness, necessity, and effectiveness of selected medical treatments and surgical procedures in the

Medicaid population. Study methodologies include analysis of geographic variations in utilization; medical records review; analysis of pregnancy outcomes; analysis of preventable morbidity and mortality; and analysis of treatments and outcomes of care.

During Phase I of the study, which is almost completed, we looked at the utilization of over 160 inpatient and outpatient treatments and procedures in the Medicaid and non-Medicaid populations. Preliminary results indicate that, overall, utilization was higher in the Medicaid population. Analysis of variations in utilization will not establish whether access or appropriateness problems exist. Rather, it will be useful for identifying potential problem areas which can then be looked at more carefully.

Phase II of the study will report on treatment effectiveness, preventable morbidity and mortality, obstetrical care, and medical records review. These data will help fill the remaining gaps in existing knowledge concerning the quality of care rendered to Medicaid recipients.

**THE UNINSURED**

Medicaid has achieved its goal of providing care for the most vulnerable and indigent. We must remember, however, that the Medicaid program was **not** established to provide health insurance coverage for all the nation.

The Administration is concerned about those Americans without adequate health insurance coverage. As vice-chair of Secretary Sullivan's task force on the uninsured, I am actively involved with the White House Domestic Policy Council work group studying this subject.

The Pepper Commission has recently recommended solutions to the problem of access to health care and long-term care, but many have questioned our ability to finance the projected level of increased spending. The Advisory Council on Social Security is also examining this critical area and is expected to submit recommendations early in 1991.

In addition, the National Governor's Association is reviewing the uninsured issue within the broader context of State domestic policy concerns. Their report is scheduled for release in June of 1991.

**CONCLUSION**

Medicaid is a complex program. Congress constructed it to be partially funded by the Federal government and fully administered by the States. As such, the States have implemented 50 different programs structured to meet the particular needs of their populations.

I have every confidence that States can continue to serve

their vulnerable populations despite demands on limited resources, by responsibly establishing priorities for their programs and by pursuing innovations in health care delivery.

It is my priority to see that State's receive every assistance available from HCFA to ensure quality care for all Medicaid recipients.

Mr. WEISS. Thank you very much.

Let me start off by asking when your first report will be coming out for expanding care for those who are not covered.

Dr. WILENSKY. I do not have a specific date, and I do not know whether or not there will be a specific release by the Department of Health and Human Services, or whether it will be part of an administration strategy. My best estimate of the timetable is that we in the Department will be forwarding our recommendations to the Domestic Policy Council sometime early in 1991. It will be reviewed by the work group, along with the Advisory Council on Social Security, which is scheduled now to report at the end of March 1991.

It is my understanding that during this period there will also be attention given to the National Governors' Association report, which is expected a month or two later, and it is my expectation the review of these various recommendations will form the basis of the recommendation by the Domestic Policy Council, headed by the Secretary, to the President.

There may be an interim release of information by the Department during that period. There has been some discussion of that over time. If there has been a final decision I am not aware of it.

Mr. WEISS. Thank you. It is good to hear you are in fact moving forward with that, because Congress, I think, also, as I have indicated before, will be moving on a—I don't know how fast a track, but will be addressing the issue certainly very early on, and throughout this coming Congress.

Let me ask you about the GAO report that really is the focus for the hearing today. GAO found that the Medicaid matching formula does not fairly take into account the differences in resources among the States. You testified that HCFA has reviewed the formula and found per capita income does take into account variations of State wealth.

When were those studies conducted, and by whom? Are those publicly available?

Dr. WILENSKY. You are talking now—not about the GAO report, about HCFA studies?

Mr. WEISS. Your study on the per capital formula.

Dr. WILENSKY. My understanding is there were some studies done in the 1980's by the Office of Research and Demonstration that looked at implications of varying some of the Medicaid match rates. I know there has been an update as well of the 1983 GAO study, although we have not yet seen it, it has not yet been released. There are not, to the best of my knowledge, any studies currently underway that are specifically looking at issues of Medicaid match rates and implications of changing them, or specifically at the issue of whether or not per capita income is the most appropriate base to use for the Medicaid match.

Mr. WEISS. GAO, as you know, has substantial evidence to support its conclusion, including differences in poverty, income and tax capacity. Will you at least do a detailed review of that and share it with us so in fact we can have your best thinking on the subject?

Dr. WILENSKY. We would be very pleased to review and give you comments on the GAO report.

[The information follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

JAN 14 1991

The Honorable Ted Weiss
Chairman
Subcommittee on Human Resource and
Intergovernmental Affairs
Committee on Government Operations
House of Representatives
Washington, D.C. 20515

Dear Mr. Weiss:

I am responding to your request at the December 7, 1990, hearing that the Health Care Financing Administration provide the Subcommittee with comments on the General Accounting Office's (GAO's) suggested changes to the Medicaid matching formula.

Overall, we find it difficult to evaluate the GAO's proposal since we have only their general congressional statement and no other details to review. The major aspect of the GAO proposal as described in Janet Shikle's statement would modify the current formula to use "total taxable resources" (TTR) as a measure of State need in allocating Federal Medicaid funds. However, the statement did not contain the alternate formula developed to calculate how the Federal match would change and how funds would be redistributed using the TTR methodology.

As I noted in my statement, any change made in the matching formula, within a budget neutral context, could result in a significant redistribution of Federal funds with consequent "winners and losers." I continue to believe that any such modification should be considered within a broader context of health care reform, such as that now under discussion by various groups, including a task force within the Department.

I can assure you that I am committed to working with States to maximize efficient use of State and Federal dollars for services to Medicaid recipients. Please let me know if I can provide you with any additional information.

Sincerely,

Gail R. Wilensky, Ph.D.
Administrator

Mr. WEISS. GAO found States with similar per capita incomes had different poverty rates. For example, Arkansas and Utah have the same per capita income, yet Arkansas' poverty rate is 57 percent higher than Utah.

Wouldn't that be some proof of the formula's unfairness and inaccuracy?

Dr. WILENSKY. I think those two pieces of information reflect two different factors that impact State spending on Medicaid. One is the ability to finance expenditures, and one is the likely need for expenditures. And I assume for simplicity's purpose, the one measure, per capita income, was used to reflect both.

It is my opinion, more as a public economist than as a HCFA Administrator, that given the likelihood as part of the review now going on about what to do for the uninsured, and what that may mean for changing public programs as well as trying to promote more private insurance coverage, that to undertake at the present time significant changes in financing Medicaid with the resultant winners and losers that budget neutrality would require, or other difficulties if budget neutrality were not withheld, may be something that ought to occur when we decide how, if at all, to change Medicaid.

You have more experience in the political ramifications of trying to make significant changes in a budget neutral context than I do, but it strikes me that especially since we are including the implications of changes in public programs, as well as private insurance, to reach out to the uninsured populations—as all other groups that are studying this issue have done—might be something that ought to be best considered when we make some decisions, because there will be lots of changes at the time.

I just worry about the difficulty of having significant changes in a cost neutral context, and given all the expansions that just occurred in OBRA 1990, to contemplate changing Medicaid match rates outside of a budget neutral context has a whole set of problems of its own.

I think you are raising a legitimate issue as to whether the formula we have used in the past is the very best one we could use. It seems to me when we are clear about how we are going to change the program, it might be easier at that point, when we have a very specific set of new objectives that we are trying to accomplish, to incorporate changes that are generally regarded as more equitable.

Mr. WEISS. Well, I thank you for the response. I am sure that it occurs to you that there is sort of an anomaly at a time when we are saying there ought to be some concern as to whether in fact people should receive benefits which they don't really need as badly as other people need, to have a system where—according to the GAO report that says $3.2 billion imbalance, because the nature of this formula which seems to provide assistance on an inaccurate basis, so in fact the neediest States, the neediest people don't get the coverage because of the formula itself.

Not because you can't identify, or because the formula when it was first adopted wasn't sensible, but in 25 years has sort of grown out of synch, and so somewhere along the line it seems to me you have to take note of that. Because otherwise what you do is spend the resources exactly in the areas where they are least needed.

Dr. WILENSKY. It is also particularly important at a time when we have increased what we demand of the States in terms of what they do, as we have in OBRA 1986, and OBRA 1989, and OBRA 1990.

Mr. WEISS. Thank you very much. I would very much like you addressing the report and the testimony we got from GAO. Maybe we have to wait until the whole world has been re-created, but maybe we don't.

That concludes our hearing. The subcommittee will stand adjourned, subject to the call of the Chair, and again we are very appreciative of all the witnesses that came and testified.

[Whereupon, at 11:15 a.m., the subcommittee adjourned, to reconvene subject to the call of the Chair.]

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